
From: Halstenson, Gentle
Sent: 1/18/2019 5:01:22 PM
To: MacLeod, Kim (DOH)
Subject: RE: CD Epi Support for GCD - Clark County

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 *attachments\D049421212A84CDC_image034.png*
 *attachments\2130D08B1D374601_image010.jpg*
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 *attachments\AFAABD2C25854418_image009.jpg*
 *attachments\08CFDFE4C786429E_image033.jpg*
 *attachments\4E9CEC889B1040EC_image002.jpg*

She stopped by to check in shortly after your email was sent and I provided update.
Thanks again for your assistance

Have a great weekend!

<<https://www.clark.wa.gov/>>

Gentle Halstenson, BSN RN

Public Health Nurse II
INFECTIOUS DISEASE

564.397.8182

<<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>>
<<https://twitter.com/ClarkCoWA>> <<https://www.youtube.com/user/ClarkCoWa/>>

From: MacLeod, Kim (DOH) [mailto:kim.macleod@doh.wa.gov]
Sent: Friday, January 18, 2019 3:13 PM
To: Halstenson, Gentle
Cc: Boysun, Mike (DOH)
Subject: RE: CD Epi Support for GCD - Clark County

Thanks Gentle!

I know Monica is probably super busy, but if you wouldn't mind closing the loop with her to communicate this plan I would really appreciate it! Just want to make sure she is kept informed, and that we are fulfilling her original request for assistance.

Thanks, and have a great weekend!

Kim

KIM MACLEOD
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Office of Communicable Disease Epidemiology
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Washington State Department of Health
kim.macleod@doh.wa.gov
206-418-5646 | www.doh.wa.gov
206-418-5500 | Fax- 206-364-1060
Gender Pronouns: she/her
<<https://www.doh.wa.gov/Newsroom/SocialMedia>>

From: Halstenson, Gentle [mailto:Gentle.Halstenson@clark.wa.gov]
Sent: Friday, January 18, 2019 2:47 PM
To: MacLeod, Kim (DOH) <kim.macleod@doh.wa.gov>
Subject: RE: CD Epi Support for GCD - Clark County

That's great, your help is much appreciated!

<<https://www.clark.wa.gov/>>

Gentle Halstenson, BSN RN
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From: MacLeod, Kim (DOH) [mailto:kim.macleod@doh.wa.gov]
Sent: Friday, January 18, 2019 2:37 PM
To: Halstenson, Gentle

Cc: Boysun, Mike (DOH)
Subject: RE: CD Epi Support for GCD - Clark County

Hi Gentle – thanks for the quick turn around on this! We're happy to help any way we can.

Let's start with this for Tuesday, and we can re-assess if there's more/less you would like us to do later in the week?

1. NEW CASES - Clark Cases with no investigator assigned for CAMPY and GIAR only, aged 5 or less only
 - a. Kim will assign these to the FB Epis for investigation/interview
2. COMPLETED CASES WITH NEW LAB - Clark cases that are completed, but new lab reports come in to be reviewed
 - a. Kim will assign these to the DOH investigator by disease area for review
3. MANUAL LABS - Clark can fax/email all their paper/manual lab reports and we will enter them in WDRS, either as new case or attaching to an existing case.
 - a. Please fax to 206-362-2486, attn.: Kim MacLeod

Let me know if this looks good, and we'll plan on starting here!

Thanks,

Kim M

KIM MACLEOD
Data Support Unit Program Supervisor
Office of Communicable Disease Epidemiology
Division of Disease Control and Health Statistics
Washington State Department of Health
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From: Halstenson, Gentle [mailto:Gentle.Halstenson@clark.wa.gov]
Sent: Friday, January 18, 2019 1:50 PM
To: MacLeod, Kim (DOH) <kim.macleod@doh.wa.gov>
Cc: Boysun, Mike (DOH) <Mike.Boysun@DOH.WA.GOV>
Subject: RE: CD Epi Support for GCD - Clark County

Hi Kim,

Thanks for reaching out, I also received your voicemail. I think the suggestions look great. For right now, I am the only one working on general CD so any help is appreciated.

If the team can implement working on number 2, that would be helpful, with just reviewing any new labs that come in for cases we already know about/ completed.

Also, number 3 would be very helpful. I can fax the paper labs in and that would save time if someone else could create the case, I can be working on the quick follow-up items (like PEP for a pertussis patient).

The other suggestion I have is for any campy and giardia cases. We typically don't

investigate/interview due to limited resources unless the person is aged 5 or less. Could those be worked by someone at the state?

If we start on Tuesday that would be fine. I think those items would be great help (based on my current workload) but we can just touch base if it becomes more overwhelming next week, if you think that's reasonable.

What number would I fax the paper labs that come in to?

Let me know if you think this sounds acceptable-

Thank you for your help!

<<https://www.clark.wa.gov/>>

Gentle Halstenson, BSN RN
Public Health Nurse II
INFECTIOUS DISEASE

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Hi Gentle –

I just left you a voicemail as well – wanted to connect on how best we can support Clark with non-Measles investigations :-)

We came up with a couple of suggestions, and I was hoping to chat with you to see which of these (if any) might be helpful, or if you have other needs and ideas about how this might work best.

Proposal to support Clark with non-measles case investigation - UPDATED

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Open issues/questions:

- * We can do any/all of this, whatever works for Clark (or other tasks identified)
- * When do we want to start this?
- * Are there any condition-specific protocols?
- * Does Clark want to be aware of these investigations at all or be directly involved
- * Does Clark County have a COOP plan that might be able to guide prioritization of cases?

Please give me a call or email at your convenience to discuss – our Epis have been prepped and readied for support tasks once we've confirmed what we'll be taking on .

Thanks,

Kim M

KIM MACLEOD

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From: Boysun, Mike (DOH)
Sent: Friday, January 18, 2019 1:05 PM
To: MacLeod, Kim (DOH) <kim.macleod@doh.wa.gov>
Subject: FW: CD Epi Support for GCD - Clark County

From: Czapla, Monica [mailto:Monica.Czapla@clark.wa.gov]
Sent: Friday, January 18, 2019 12:58 PM
To: Matheson, Jasmine S (DOH) <Jasmine.Matheson@DOH.WA.GOV>
Cc: Boysun, Mike (DOH) <Mike.Boysun@DOH.WA.GOV>; Harry, Cynthia S (DOH) <cynthia.harry@doh.wa.gov>; DOH-OSC (DOH) <doh-osc@doh.wa.gov>
Subject: RE: CD Epi Support for GCD - Clark County

Halstenson, Gentle <Gentle.Halstenson@clark.wa.gov>

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Monica Czapla, MPH
Program Manager - Infectious Diseases
PUBLIC HEALTH

564.397.8002 (note: our office area code has changed)
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From: Matheson, Jasmine S (DOH) [mailto:Jasmine.Matheson@DOH.WA.GOV]
Sent: Thursday, January 17, 2019 6:02 PM
To: Czapla, Monica
Cc: Boysun, Mike (DOH); Harry, Cynthia S (DOH); DOH-OSC (DOH)
Subject: CD Epi Support for GCD - Clark County

Hi Monica

Our office is able to assist in supporting GCD investigations for Clark County.

Points of contact:

- * VPD (non-measles outbreak): Amy Poel
- * Enterics: Beth Melius
- * Zoonotic Diseases: Hanna Oltean
- * Influenza/Legionella: Vivian Hawkins
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Does Clark County have a COOP plan that might be able to guide prioritization of cases?

If you could please connect Mike Boysun and Cynthia Harry to the best person from your staff to facilitate transition of GCD work, the subject matter leads can provide suggestions and jointly plan to ensure effective follow-up.

Thanks and see you tomorrow.
Jasmine

Jasmine Matheson, MPH
Program Manager / Refugee Health Coordinator
Disease Control and Health Statistics
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From: Dykstra, Elizabeth A (DOH)
Sent: 1/17/2019 8:21:56 AM
To: Kangiser, David (DOH), nicolamh@hotmail.com, Stephen Rich (smrich@umass.edu), gxu@umass.edu, gxu@psis.umass.edu Xu (gxu@psis.umass.edu), Eisen, Rebecca J. (CDC/OID/NCEZID), Graham, Christine B. (CDC/OID/NCEZID), 'Morshed, Muhammad', Lee, Min-Kuang (Min-Kuang.Lee@bccdc.ca)
Subject: WA TBD Manuscript



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attachments\1C85ED912A644AD5_Epidem TB Path WA Jan19 Supplemental Data.docx

Good morning all,

Attached is a manuscript we at DOH have been working on that details findings of our tick surveillance testing and TBD human cases through 2016. Because you played a critical role in this work, we would like to include you as an author. If you feel that you would rather not be an author, please let me know and I will move your name to the acknowledgements section.

Due to the fact that we're still completing testing of 2017 and 2018 ticks, we focused on data through 2016.

If you could return your comments to me by January 31, that would be greatly appreciated. Additionally, if you could let me know of any additional approval processes your institution requires, that will be appreciated as well.

Finally, I'd like to thank you for helping us make this work happen. It's tremendously exciting to find out what's percolating in our tick populations out here!

r/
LIZ DYKSTRA, PHD, BCE
Public Health Entomologist
Zoonotic Disease Program
Environmental Public Health Division
Washington State Department of Health
elizabeth.dykstra@doh.wa.gov
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<<https://www.doh.wa.gov/Newsroom/SocialMedia>>

From: MacLeod, Kim (DOH)
Sent: 1/18/2019 1:38:33 PM
To: Gentle.Halstenson@clark.wa.gov
Subject: FW: CD Epi Support for GCD - Clark County



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attachments\CD71E0E2DAFF4A9B_image004.png



attachments\ADF0BB0BEB7F4848_image005.jpg

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To: Matheson, Jasmine S (DOH) <Jasmine.Matheson@DOH.WA.GOV>
Cc: Boysun, Mike (DOH) <Mike.Boysun@DOH.WA.GOV>; Harry, Cynthia S (DOH) <cynthia.harry@doh.wa.gov>; DOH-OSC (DOH) <doh-osc@doh.wa.gov>
Subject: RE: CD Epi Support for GCD - Clark County

Halstenson, Gentle <Gentle.Halstenson@clark.wa.gov>

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Monica Czapla, MPH
Program Manager - Infectious Diseases
PUBLIC HEALTH

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Jasmine

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This e-mail and related attachments and any response may be subject to public disclosure under state law.

From: Roberts, Michele (DOH)
Sent: 1/15/2019 5:59:39 PM
To: Chappell, Shauntrelle L. (CDC/OID/NCIRD)
Subject: measles outbreak



attachments\60E43696A4AD4FD8_image002.png

Hi Shauntrelle –

Head's up that we have a rapidly growing measles outbreak in Washington that is also impacting Oregon, Georgia and Hawaii. Right now I think we have at least 5 confirmed cases and 8 suspect cases, and that is changing rapidly. Our agency did go into incident response for this.

The communicable disease office, which is a separate office, is the lead for the outbreak and already working closely with CDC and other states. We are still determining if there is additional vaccine that is needed, and anticipate at this point we have enough in VFC and 317 vaccine funding to support our needs at this time.

Please let us know if you have any questions. We will do our best to keep you updated as things move forward, and please reach out anytime if you have questions.

Thanks!

Michele

Michele Roberts, MPH, MCHES
Director, Office of Immunization and Child Profile
Prevention and Community Health Division
Washington State Department of Health
Michele.Roberts@doh.wa.gov
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<<https://www.doh.wa.gov/Newsroom/SocialMedia>>

From: Czapla, Monica
Sent: 1/15/2019 10:02:45 PM
To: Lippman, Soyeon I (DOH)
Subject: Re: CD Epi Measles contact



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Thank you all at DOH for your support, VERY much appreciated.

My CD Team - see emails below, Soyeon is our measles go to person.

Yelena- for specimens, please email Soyeon and copy Jasmine Matheson, and let them know number of specimens and tracking number moving forward.

Monica

Sent from my iPhone

On Jan 15, 2019, at 9:57 PM, Lippman, Soyeon I (DOH) <soyeon.lippman@doh.wa.gov> wrote:

Greetings everyone,

Thank you, Amy, for your kind note. I learned from the best – that is, Chas & Amy.

Please allow me to clarify that I'm at the office:

- * Mon, Tues, Wed, Fri – All day.
- * Thurs – 7:30 to 11am.

I'm truly looking forward to working with everyone.

In warm regards,
Soyeon

Soyeon Lippman, PhD
Epidemiologist | Tribal Liaison
Office of Communicable Disease Epidemiology
Division of Disease Control & Health Statistics
Washington State Department of Health
soyeon.lippman@doh.wa.gov
206-418-5590 | www.doh.wa.gov
<image002.png><image004.png><image006.png><image008.png><image010.png>

From: Poel, Amy J (DOH)
Sent: Tuesday, January 15, 2019 4:10 PM
To: Carlson, Alyssa (DOHi) <Alyssa.Carlson@clark.wa.gov>; Halstenson, Gentle <Gentle.Halstenson@clark.wa.gov>; Czaplá, Monica <Monica.Czapla@clark.wa.gov>; Riethman, Madison (DOHi) <Madison.Riethman@clark.wa.gov>
Cc: Lippman, Soyeon I (DOH) <soyeon.lippman@doh.wa.gov>; Matheson, Jasmine S (DOH) <Jasmine.Matheson@DOH.WA.GOV>; DeBolt, Chas (DOH) <Chas.DeBolt@DOH.WA.GOV>; Boysun, Mike (DOH) <Mike.Boysun@DOH.WA.GOV>; Graff, Nicholas R (DOH) <nicholas.graff@doh.wa.gov>
Subject: CD Epi Measles contact

Hello all,

So that you will have excellent dedicated support here in CD Epi, Soyeon Lippman is going to take over for me as the person handling the DOH measles linelist, coordinating measles specimen testing, communicating measles lab testing results to you, and doing anything else you may need here from CD Epi. She will be performing these tasks M-R all day and Friday until noon. You can contact me after noon on Friday. You can reach her at the above e-mail or call her directly at 206-418-5590.

I will be handling all of the other VPD's (AFM, pertussis, diphtheria, tetanus, mumps, rubella, mening, h flu, varicella) and will be in the office and reachable through phone and email.

Amy

Amy J. Poel
Epidemiologist/Vaccine Preventable Disease Coordinator
Office of Communicable Disease Epidemiology
Division of Disease Control and Health Statistics
Washington State Department of Health
Amy.Poel@doh.wa.gov
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Thanks Gentle!

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Kim

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Hi Gentle – thanks for the quick turn around on this! We're happy to help any way we can.

Let's start with this for Tuesday, and we can re-assess if there's more/less you would like us to do later in the week?

1. NEW CASES - Clark Cases with no investigator assigned for CAMPY and GIAR only, aged 5 or less only
 - a. Kim will assign these to the FB Epis for investigation/interview
2. COMPLETED CASES WITH NEW LAB - Clark cases that are completed, but new lab reports come in to be reviewed
 - a. Kim will assign these to the DOH investigator by disease area for review
3. MANUAL LABS - Clark can fax/email all their paper/manual lab reports and we will enter them in WDRS, either as new case or attaching to an existing case.
 - a. Please fax to 206-362-2486, attn.: Kim MacLeod

Let me know if this looks good, and we'll plan on starting here!

Thanks,

Kim M

KIM MACLEOD
Data Support Unit Program Supervisor
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Division of Disease Control and Health Statistics
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kim.macleod@doh.wa.gov

206-418-5646 | www.doh.wa.gov
206-418-5500 | Fax- 206-364-1060
Gender Pronouns: she/her
<<https://www.doh.wa.gov/Newsroom/SocialMedia>>

From: Halstenson, Gentle [mailto:Gentle.Halstenson@clark.wa.gov]
Sent: Friday, January 18, 2019 1:50 PM
To: MacLeod, Kim (DOH) <kim.macleod@doh.wa.gov>
Cc: Boysun, Mike (DOH) <Mike.Boysun@DOH.WA.GOV>
Subject: RE: CD Epi Support for GCD - Clark County

Hi Kim,

Thanks for reaching out, I also received your voicemail. I think the suggestions look great. For right now, I am the only one working on general CD so any help is appreciated.

If the team can implement working on number 2, that would be helpful, with just reviewing any new labs that come in for cases we already know about/ completed.

Also, number 3 would be very helpful. I can fax the paper labs in and that would save time if someone else could create the case, I can be working on the quick follow-up items (like PEP for a pertussis patient).

The other suggestion I have is for any campy and giardia cases. We typically don't investigate/interview due to limited resources unless the person is aged 5 or less. Could those be worked by someone at the state?

If we start on Tuesday that would be fine. I think those items would be great help (based on my current workload) but we can just touch base if it becomes more overwhelming next week, if you think that's reasonable.

What number would I fax the paper labs that come in to?

Let me know if you think this sounds acceptable-

Thank you for your help!

<<https://www.clark.wa.gov/>>

Gentle Halstenson, BSN RN
Public Health Nurse II
INFECTIOUS DISEASE

564.397.8182

<<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>>
<<https://twitter.com/ClarkCoWA>> <<https://www.youtube.com/user/ClarkCoWa/>>

From: MacLeod, Kim (DOH) [mailto:kim.macleod@doh.wa.gov]
Sent: Friday, January 18, 2019 1:39 PM
To: Halstenson, Gentle
Cc: Boysun, Mike (DOH)
Subject: FW: CD Epi Support for GCD - Clark County

Hi Gentle –

I just left you a voicemail as well – wanted to connect on how best we can support Clark with non-Measles investigations :-)

We came up with a couple of suggestions, and I was hoping to chat with you to see which of these (if any) might be helpful, or if you have other needs and ideas about how this might work best.

Proposal to support Clark with non-measles case investigation - UPDATED

1. NEW CASES - Clark Cases with no investigator assigned
 - a. Kim will assign these to the DOH investigators by disease area
2. COMPLETED CASES WITH NEW LAB - Clark cases that are completed, but new lab reports come in to be reviewed
 - a. Kim will assign these to the DOH investigator by disease area
3. MANUAL LABS - Clark can fax/email all their paper/manual lab reports and we will enter them in WDRS, either as new case or attaching to an existing case
4. STARTED CASES - Clark cases that are “in flight” with an investigator assigned – Clark can request assistance on a case-by-case basis

Open issues/questions:

- * We can do any/all of this, whatever works for Clark (or other tasks identified)
- * When do we want to start this?
- * Are there any condition-specific protocols?
- * Does Clark want to be aware of these investigations at all or be directly involved
- * Does Clark County have a COOP plan that might be able to guide prioritization of cases?

Please give me a call or email at your convenience to discuss – our Epis have been prepped and readied for support tasks once we’ve confirmed what we’ll be taking on .

Thanks,

Kim M

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Gender Pronouns: she/her
<<https://www.doh.wa.gov/Newsroom/SocialMedia>>

From: Boysun, Mike (DOH)
Sent: Friday, January 18, 2019 1:05 PM
To: MacLeod, Kim (DOH) <kim.macleod@doh.wa.gov>
Subject: FW: CD Epi Support for GCD - Clark County

From: Czapla, Monica [mailto:Monica.Czapla@clark.wa.gov]

Sent: Friday, January 18, 2019 12:58 PM
To: Matheson, Jasmine S (DOH) <Jasmine.Matheson@DOH.WA.GOV>
Cc: Boysun, Mike (DOH) <Mike.Boysun@DOH.WA.GOV>; Harry, Cynthia S (DOH) <cynthia.harry@doh.wa.gov>; DOH-OSC (DOH) <doh-osc@doh.wa.gov>
Subject: RE: CD Epi Support for GCD - Clark County

Halstenson, Gentle <Gentle.Halstenson@clark.wa.gov>

<<https://www.clark.wa.gov/>>

Monica Czapla, MPH
Program Manager - Infectious Diseases
PUBLIC HEALTH

564.397.8002 (note: our office area code has changed)
360.836.9086 cell

<<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>>
<<https://twitter.com/ClarkCoWA>> <<https://www.youtube.com/user/ClarkCoWa/>>

From: Matheson, Jasmine S (DOH) [mailto:Jasmine.Matheson@DOH.WA.GOV]
Sent: Thursday, January 17, 2019 6:02 PM
To: Czapla, Monica
Cc: Boysun, Mike (DOH); Harry, Cynthia S (DOH); DOH-OSC (DOH)
Subject: CD Epi Support for GCD - Clark County

Hi Monica

Our office is able to assist in supporting GCD investigations for Clark County.

Points of contact:

- * VPD (non-measles outbreak): Amy Poel
- * Enterics: Beth Melius
- * Zoonotic Diseases: Hanna Oltean
- * Influenza/Legionella: Vivian Hawkins
- * Hepatitis B (acute): Marcia Goldoft
- * HAI: Sara Podczervinski

We are currently able to support creating cases in WDRS, investigation and public health actions and data entry. For each condition area it will be important to transition existing Clark County cases and establish any condition-specific protocols. Currently there are 19 open investigations in WDRS for Clark County. For new cases, we'll need to set up designated processes and address condition specific questions. For example, investigation of immediately notifiable conditions and public health actions – does Clark want to be aware of these investigations at all or be directly involved (e.g., prophylaxis)?

Does Clark County have a COOP plan that might be able to guide prioritization of cases?

If you could please connect Mike Boysun and Cynthia Harry to the best person from your staff to facilitate transition of GCD work, the subject matter leads can provide suggestions and jointly plan to ensure effective follow-up.

Thanks and see you tomorrow.
Jasmine

Jasmine Matheson, MPH
Program Manager / Refugee Health Coordinator
Disease Control and Health Statistics
Washington State Department of Health
jasmine.matheson@doh.wa.gov
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From: EPIXUpdate@cdc.gov
Sent: 1/16/2019 2:12:18 AM
To: Boysun, Mike (DOH)
Cc:

Epi-X reports posted in your areas of interest in the past 24 hours. To view a specific report, click on its URL.

UPDATE DGMQ Measles Notification: Contact List for Flight DAL 0608 to ATL 01/07/2019
(DGMQ ID 196146) - WA
Update to clinical notes. Flight was not on 1/13
<https://epix2.cdc.gov/v2/Reports/Display.aspx?id=69276>

UPDATE DGMQ Measles Notification: Contact List for Flight DAL 0608 to ATL 01/07/2019
(DGMQ ID 196150) - WA
Update to Clinical notes. Flight was not on 1/13
<https://epix2.cdc.gov/v2/Reports/Display.aspx?id=69270>

DGMQ Measles Notification: Contact List for Flight DAL 0608 to ATL 01/07/2019 (DGMQ ID 196150) - WA

The attached file contains names of persons assigned to your jurisdiction, based on available information, who may have been exposed to Measles on a flight.

<https://epix2.cdc.gov/v2/Reports/Display.aspx?id=69261>

DGMQ Measles Notification: Contact List for Flight DAL 0608 to ATL 01/07/2019 (DGMQ ID 196146) - WA

The attached file contains names of persons assigned to your jurisdiction, based on available information, who may have been exposed to Measles on a flight.

<https://epix2.cdc.gov/v2/Reports/Display.aspx?id=69253>

~*~ Global Immunization News Report, January 14, 2019 ~*~
Today's Global Immunization News report includes polio, measles, mumps, cholera, acute flaccid myelitis, policy and funding, vaccine demand and safety, and other news for Monday, January 14, 2019.
<https://epix2.cdc.gov/v2/Reports/Display.aspx?id=69247>

Media Tracking Report, January 15, 2019

Media stories include norovirus and an opioid overdose in California; hepatitis A in Illinois; pertussis in Kentucky; scabies in Michigan; acute flaccid myelitis and measles in multiple states; hantavirus in Argentina; cholera in Zimbabwe; leprosy in India; Ebola in DRC; and other media coverage.

<https://epix2.cdc.gov/v2/Reports/Display.aspx?id=69245>

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From: Susan Turner


Sent: 1/16/2019 12:58:34 PM


To: Flake, Marie D (DOH), Black, Ryan (DOH), Bodden, Jaime (DOHi), Burkland, Anne (DOHi), Calder, Allegra (DOHi), Courogen, Maria (DOH), Davis, Michelle (DOH), Debolt, Meghan (DOHi), Delahunt, Regina (DOHi), Dzedzy, Ed (DOHi), Goelz, Mary (DOHi), Halvorson, Clark R (DOH), Joyner, Pama (DOH), Ketchel, Jeff (DOHi), Kirkpatrick, Vicki (DOHi), Lindquist, Scott W (DOH), Melnick, Alan (DOHi), Miller, Angi (DOH), Rohr Tran, Holly (DOHi), Schanz, Matt (DOHi), Schuler, Christopher (DOHi), Tammy Axlund, Wilson, Lyndia (DOHi), Windom, David (DOHi), Wolfe, Roxanne (DOHi), Worsham, Dennis (DOHi), York, Danette (DOHi)


Cc:


Subject: RE: FPHS TWG Meeting 1/18/19


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 *attachments\DE92A6AEB1294AFA_image014.png*

 *attachments\D3AAB8B7FFA74511_image006.png*

 *attachments\F2F377B43EA94679_image004.png*

Hi Marie. I've noted some comments in bold and red font below. I'll have this list with me when we talk on Friday, but I thought it would be helpful for us to have the chance to start thinking about responses before the meeting. Thank you as always for helping us to be well prepared for our meetings! Sincerely, Susan

Susan Turner MD, MPH, MS | Health Officer
Kitsap Public Health District
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<<http://www.kitsappublichealth.org/>>

<<https://www.facebook.com/KitsapPublicHealthDistrict>>

From: Flake, Marie D (DOH) <marie.flake@doh.wa.gov>
Sent: Friday, January 11, 2019 1:57 PM

To:

Subject: FPHS TWG Meeting 1/18/19

Dear TWG,

Happy New Year. We scheduled to meet next Friday, 1/18, 1:30-3pm to finalize the functional definitions – for this moment in time. Connection info is below and should be on your calendar.

Attached is the final draft version we have used for the past year with the tweaks this group settled on in December shown using track changes. I also incorporated the comment receive by e-mail from Susan after that meeting. Below is a summary of the proposed changes. Please review in advance so we can complete this task during the meeting. If you are not able to participate in the meeting, please send your comments in advance. Thank you.

Connection

* Webinar: <https://global.gotomeeting.com/join/990414661>

* Audio by phone: (872) 240-3212 / Access Code: 990-414-661

Summary of Proposed Changes to Functional Definitions – for discussion/approval by TWG on 1/18/19

* Page 29, G (CD) 1 (Data) – b (Immunization Information System) – Centralized Activity; c, d, f – adding effort for data input, quality, educating providers.--Agree

* Page 31, G (CD) 3 (Immunizations) & b – adding effort for promoting IIS and data input, quality, educating providers. Isn't the registry called the Washington IIS, or WIIS?

* Page 32, G (CD) 4 (Investigation) d – adding efforts to collect, package, ship and test CD samples; e – receive case reports from providers, labs and other reporters. In 4d recommend adding "package" between "...specimens," and "ship,"—thanks for adding "other reporters to 4.e.

* Page 34, G (CD) 5 (PHL) – Centralized Activity with support from PHSKC—Agree with changes, and agree with comment in margin that 24/7 COOP for LHJs to reach the lab and send specimens is covered in G.4.k.

* Page 41 & 42, I (EH) 3 (Investigations) – adding efforts to collect, package, ship and test EH samples—Page 42 G.3.j. needs to have "package" added as in the third bullet above

* Page 47, J (MCH) 3 (Newborn screening) – Centralized Activity--Agree

* Page 50, K (Access) 3 (Licensing) – Centralized Activity--Agree

* Page 52, L (VR) 1 (Data system) – Centralized Activity—Agree IF DOH is the only entity that does all of the functions (don't locals do L.1.d., e. f. g?)—also one thing I don't see is any local review of birth/death records for surveillance. Not sure LHJs do this, but I have heard rumors about Health Officers wanting to be informed for suspicious causes of death that represent public health threats, especially as relates to several proximate deaths due to one cause, infant and child deaths, or environmental threats. I don't know whether the TWG ever talked about that as an FPHS...

Talk with you next week.











Marie

Marie Flake
Special Projects

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<<https://www.youtube.com/channel/UCTSCpezTD0TjiiAOuJY7f5w/doh>>
<<https://medium.com/@WADeptHealth>>

From: Lippman, Soyeon I (DOH)
Sent: 1/15/2019 9:57:02 PM
To: Poel, Amy J (DOH), Carlson, Alyssa (DOHi), Halstenson, Gentle, Czapla, Monica, Riethman, Madison (DOHi)
Subject: RE: CD Epi Measles contact

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 *attachments\63F60754D3FC4BFE_image013.png*
 *attachments\111FC2F270AE418A_image010.png*
 *attachments\9AD8F49E7F484A7F_image008.png*
 *attachments\C8D30EEEB8B242E6_image012.png*
 *attachments\59A4D3129A7A493B_image014.png*
 *attachments\688F852BB06342E0_image006.png*

Greetings everyone,

Thank you, Amy, for your kind note. I learned from the best – that is, Chas & Amy.

Please allow me to clarify that I'm at the office:

- * Mon, Tues, Wed, Fri – All day.
- * Thurs – 7:30 to 11am.

I'm truly looking forward to working with everyone.

In warm regards,
Soyeon

Soyeon Lippman, PhD
Epidemiologist | Tribal Liaison
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Division of Disease Control & Health Statistics
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From: Poel, Amy J (DOH)
Sent: Tuesday, January 15, 2019 4:10 PM
To: Carlson, Alyssa (DOHi) <Alyssa.Carlson@clark.wa.gov>; Halstenson, Gentle <Gentle.Halstenson@clark.wa.gov>; Czapla, Monica <Monica.Czapla@clark.wa.gov>; Riethman, Madison (DOHi) <Madison.Riethman@clark.wa.gov>
Cc: Lippman, Soyeon I (DOH) <soyeon.lippman@doh.wa.gov>; Matheson, Jasmine S (DOH) <Jasmine.Matheson@DOH.WA.GOV>; DeBolt, Chas (DOH) <Chas.DeBolt@DOH.WA.GOV>; Boysun, Mike (DOH) <Mike.Boysun@DOH.WA.GOV>; Graff, Nicholas R (DOH) <nicholas.graff@doh.wa.gov>
Subject: CD Epi Measles contact

Hello all,

So that you will have excellent dedicated support here in CD Epi, Soyeon Lippman is going to take over for me as the person handling the DOH measles linelist, coordinating measles specimen testing, communicating measles lab testing results to you, and doing anything else you may need here from CD Epi. She will be performing these tasks M-R all day and Friday until noon. You can contact me after noon on Friday. You can reach her at the above e-mail or call her directly at 206-418-5590.

I will be handling all of the other VPD's (AFM, pertussis, diphtheria, tetanus, mumps, rubella, mening, h flu, varicella) and will be in the office and reachable through phone and email.

Amy

Amy J. Poel
Epidemiologist/Vaccine Preventable Disease Coordinator
Office of Communicable Disease Epidemiology
Division of Disease Control and Health Statistics
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Gender Pronouns: She/Her
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<<https://www.youtube.com/channel/UCTSCpezTD0TjiiAOuJY7f5w/doh>>
<<https://medium.com/@WADepthHealth>>

From: STD_PCHD (CDC)

Sent: 1/18/2019 11:13:13 AM

To: Adam Visconti (Adam.Visconti@dc.gov), Greenbaum, Adena (CDC baltimorecity.gov), Shipman, Aimee (CDC dhew.idaho.gov), Gill, Amanda (CDC state.sd.us), Self, Amelia (CDC utah.gov), Gans, Andrew AG (CDC state.nm.us), Benson-Scott, Annick ABS (CDC state.or.us), Wade, Anthony (CDC dhs.wisconsin.gov), Arielle Juberg (arielle.juberg@baltimorecity.gov), Gilliard, Bernard (CDC dheh.sc.gov), Beth Butler (bebutler@pa.gov), Roberts, Brandi (CDC arkansas.gov), Wardle, Brittany (CDC wyo.gov), Conrad, Caitlin (CDC isdh.in.gov), Murolo, Cara (CDC mt.gov), Johnson, Caroline (PHILA) (CDC phila.gov), Catherine Mosley (Cathy.Mosley@state.de.us), Chang Lee (chang.lee@ky.gov), Johnson, Chaquetta (CDC la.gov), Cherie Walker-Baban (cherie.walker-baban@phila.gov), Winter, Colleen (CDC state.sd.us), White, Connie (CDC ky.gov), Highfill, Craig (CDC health.mo.gov), Wilson, Craig (CDC flhealth.gov), Daltrey, Daniel (CDC vermont.gov), Brikshavana, Danucha (CDC illinois.gov), Goudreau, David (CDC state.ma.us), Peyton, David (CDC msdh.ms.gov), Gruber, DeAnn (CDC la.gov), Debora Blankinship (debora.s.blankinship@wv.gov), Stover, Dennis (CDC isdh.in.gov), Diana Prat (diana.prat@vdh.virginia.gov), Crutsinger-Perry, Elizabeth (DOH), Elizabeth Kessler (ekessler@health.nv.gov), Huriaux, Emalie (DOH), Fratto, Erin (CDC utah.gov), Evelyn Foust (evelyn.foust@dhhs.nc.gov), Walton, George (CDC idph.iowa.gov), Hasty, Gerald (CDC doh.hawaii.gov), Olthoff, Glen (CDC baltimorecity.gov), Wasserman, Glenn (CDC doh.hawaii.gov), Greduvel Duran Guzman (gduran@salud.pr.gov), Greta Anschuetz (greta.anschuetz@doh.nj.gov), Hadiyah Charles (hadiyah.charles@doh.vi.gov), Harrison D. Wallace (acting) (harrison.wallace@adph.state.al.us), Jenkins, Heidi (CDC ct.gov), Holly Howard (Holly.Howard@cdph.ca.gov), Tabidze, Irina (CDC cityofchicago.org), Clymore, Jacquelyn (CDC dhhs.nc.gov), James (Jim) Stewart (jim.stewart@state.co.us), Vergeront, James (CDC dhs.wisconsin.gov), Watt, James (CDC cdph.ca.gov), Cotnoir, Jamie JC (CDC maine.gov), Waters, Janine (CDC state.nm.us), Javier Vazquez Melendez (javazquez@salud.pr.gov), Jennifer VandeVelde (jennifer.vandevelde@ks.gov), Weberg-Bryce, Jeri (CDC nebraska.gov), Johanny Valazquez (jovelazquez@salud.pr.gov), Joshua Ferrer (joshua.s.ferrer@state.or.us), Julie Hanson Perez (julie.hanson.perez@state.mn.us), Karen Nicosia (karen.nicosia@odh.ohio.gov), Washburn, Kate (CDC health.nyc.gov), Roosevelt, Kathleen (CDC state.ma.us), Macomber, Kathryn (CDC michigan.gov), Kathy Stone (kathy.stone@idph.iowa.gov), Ducker, Kellie (CDC health.nv.gov), Johnson, Kendra KJ (CDC msdh.ms.gov), Kenneth Ruby (kenneth.ruby@maryland.gov), Kimberly Matulonis-Edgar (Kimberly.Matulonis-Edgar@dhw.idaho.gov), Eberly, Kristen (CDC health.ok.gov), Judd-Tuinier, Kristine (CDC michigan.gov), King, Kristine (CDC pa.gov), Terry, Latasha (CDC dph.ga.gov), Laurie Rickert (Laurie.Rickert@odh.ohio.gov), Leo Moore (lmoore@ph.lacounty.gov), Leo Parker (Leo.Parker@tn.gov), Lindsay Pierce (Lindsay.pierce@dhhs.state.nh.us), VanderBusch, Lindsey (CDC nd.gov), Lisa Morris (lisa.morris@dhhs.nh.gov), Loretta Haddy (loretta.e.haddy@wv.gov), Lorlette Moir (Lorlette.Moir@dhhs.nh.gov), Sosa, Lynn (CDC ct.gov), Pearl, Marcia (CDC maryland.gov), Carroll, Margaret (CDC health.ny.gov), Perez, Mario (CDC ph.lacounty.gov), Green, Michael MG (CDC ph.lacounty.gov), Kharfen, Michael (CDC dc.gov), Mildred Banks (mildred.banks@dph.ga.gov), Massey, Nicole (CDC health.mo.gov), Vasiliu, Oana (CDC vdh.virginia.gov), Reynolds, Pamela (CDC wv.gov), Patel, Parul PP (CDC tn.gov), Villegas, Patricia (CDC michigan.gov), Paul Byers (paul.byers@msdh.ms.gov), Whiticar, Peter (CDC doh.hawaii.gov), Randy Mayer (randall.mayer@idph.iowa.gov), Rebecca Scranton (Rebecca.Scranton@azdhs.gov), Roger Follas (roger.follas@dhhs.nc.gov), Shelley Lucas (shelley.lucas@dshs.texas.gov), Stephanie Smiley (stephanie.smiley@dhs.wi.gov), Blank, Susan (CDC health.nyc.gov), Jones, Susan A. (CDC alaska.gov), Tammy Foskey (Tammy.Foskey@dshs.texas.gov), Tammy Rutledge (tammy.rutledge@cityofchicago.org), Stephens, Terri (CDC dheh.sc.gov), Bertrand, Thomas (CDC health.ri.gov), Thomas Lee (thomas.lee@adph.state.al.us), Tiffany Vance (Tiffany.vance@arkansas.gov), Aragon, Tomas MD, DrPH (CDC sfph.org), Tracy Smith

(tracy.smith2@alaska.gov), Nguyen, Trang (CDC sfdph.org), Travis O'Donnell (travis.odonnell@health.ny.gov), Adamova, Valentina (CDC health.ri.gov), Yesenia Mendez (acting) (yesenia.mendez@state.co.us)
Subject: STD PCHD Kickoff Webinar - January 17, 2019 - Slides Attached



attachments\73B13565F30D4585_CDC DSTDP STD PCHD Kick Off Webin_PRD TOOL_NAMETOOLONG.pdf

Dear STD PCHD Colleagues,

Thank you to those who were able to attend the STD PCHD Kickoff Webinar on January 17, 2019. We appreciate your time and your questions.

Please see attached for the webinar slides.

As mentioned, we will also do the following:

1. Send out the slides through GrantSolutions as a grant note (done 1/18/19)
2. Post the slides and the recording on the STD PCHD website:
<https://www.cdc.gov/std/funding/pchd/default.htm>
3. Post the Q/A document that summarizes the questions and answers from the webinar and let you know when available.
4. Send information to the project areas with an STD AAPPs NCE on the deadlines for close out reports as relates to STD AAPPs and any supplement (CS, eval, GISP).

If you have any additional questions, please reach out to your Prevention Specialist or email us at STD_PCHD@cdc.gov. Your feedback is important to us and we want to make sure that we are providing you with clear and useful information so we welcome all of your questions and comments.

Thanks,
Jennifer

From: STD_PCHD (CDC)

Sent: Wednesday, January 16, 2019 12:04 PM

To: Adam Visconti (Adam.Visconti@dc.gov) <Adam.Visconti@dc.gov>; Adena Greenbaum (adena.greenbaum@baltimorecity.gov) <adena.greenbaum@baltimorecity.gov>; Aimee Shipman (ShipmanA@dhw.idaho.gov) <ShipmanA@dhw.idaho.gov>; Amanda Gill (amanda.gill@state.sd.us) <amanda.gill@state.sd.us>; Amelia Self (aself@utah.gov) <aself@utah.gov>; Andrew Gans (andrew.gans@state.nm.us) <andrew.gans@state.nm.us>; Annick Benson-Scott (annick.benson@state.or.us) <annick.benson@state.or.us>; Anthony Wade (anthony.wade@dhs.wisconsin.gov) <anthony.wade@dhs.wisconsin.gov>; Arielle Juberg (arielle.juberg@baltimorecity.gov) <arielle.juberg@baltimorecity.gov>; Bernard Gilliard (gilliab@dhec.sc.gov) <gilliab@dhec.sc.gov>; Beth Butler (bebutler@pa.gov) <bebutler@pa.gov>; Brandi Roberts (brandi.roberts@arkansas.gov) <brandi.roberts@arkansas.gov>; Brittany Wardle (brittany.wardle@wyo.gov) <brittany.wardle@wyo.gov>; Caitlin Conrad (caconrad@isdh.in.gov) <caconrad@isdh.in.gov>; Cara Murolo (cmurolo@mt.gov) <cmurolo@mt.gov>; Caroline Carlson Johnson (caroline.johnson@phila.gov) <caroline.johnson@phila.gov>; Catherine Mosley (Cathy.Mosley@state.de.us) <Cathy.Mosley@state.de.us>; Chang Lee (chang.lee@ky.gov) <chang.lee@ky.gov>; Chaquetta Johnson (chaquetta.johnson@la.gov) <chaquetta.johnson@la.gov>; Cherie Walker-Baban (cherie.walker-baban@phila.gov) <cherie.walker-baban@phila.gov>; Colleen Winter (colleen.winter@state.sd.us) <colleen.winter@state.sd.us>; Connie White MD (connie.white@ky.gov) <connie.white@ky.gov>; Craig Highfill (craig.highfill@health.mo.gov) <craig.highfill@health.mo.gov>; Craig Wilson (craig.wilson@flhealth.gov) <craig.wilson@flhealth.gov>; Daniel Daltry

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(marcia.pearl@maryland.gov) <marcia.pearl@maryland.gov>; Margaret Carroll (margaret.carroll@health.ny.gov) <margaret.carroll@health.ny.gov>; Mario Perez (mjperez@ph.lacounty.gov) <mjperez@ph.lacounty.gov>; Michael Green Ph. D (mgreen@ph.lacounty.gov) <mgreen@ph.lacounty.gov>; Michael Kharfen (Michael.Kharfen@dc.gov) <Michael.Kharfen@dc.gov>; Mildred Banks (mildred.banks@dph.ga.gov) <mildred.banks@dph.ga.gov>; Nicole Massey (nicole.massey@health.mo.gov) <nicole.massey@health.mo.gov>; Oana Vasiliu (oana.vasiliu@vdh.virginia.gov) <oana.vasiliu@vdh.virginia.gov>; Pamela Reynolds (Pamela.S.Reynolds@wv.gov) <Pamela.S.Reynolds@wv.gov>; Parul Patel (Parul.Patel@tn.gov) <Parul.Patel@tn.gov>; Patricia Villegas (villegasp@michigan.gov) <villegasp@michigan.gov>; Paul Byers (paul.byers@msdh.ms.gov) <paul.byers@msdh.ms.gov>; Peter Whiticar (peter.whiticar@doh.hawaii.gov) <peter.whiticar@doh.hawaii.gov>; Randy Mayer (randall.mayer@idph.iowa.gov) <randall.mayer@idph.iowa.gov>; Rebecca Scranton (Rebecca.Scranton@azdhs.gov) <Rebecca.Scranton@azdhs.gov>; Roger Follas (roger.follas@dhhs.nc.gov) <roger.follas@dhhs.nc.gov>; Romni Neiman (Romni.neiman@cdph.ca.gov) <Romni.neiman@cdph.ca.gov>; Shelley Lucas (shelley.lucas@dshs.texas.gov) <shelley.lucas@dshs.texas.gov>; Stephanie Smiley (stephanie.smiley@dhs.wi.gov) <stephanie.smiley@dhs.wi.gov>; Susan Blank (sblank@health.nyc.gov) <sblank@health.nyc.gov>; Susan Jones (susan.jones@alaska.gov) <susan.jones@alaska.gov>; Tammy Foskey (Tammy.Foskey@dshs.texas.gov) <Tammy.Foskey@dshs.texas.gov>; Tammy Rutledge (tammy.rutledge@cityofchicago.org) <tammy.rutledge@cityofchicago.org>; Terri Stephens (stephetg@dhec.sc.gov) <stephetg@dhec.sc.gov>; Thomas Bertrand (thomas.bertrand@health.ri.gov) <thomas.bertrand@health.ri.gov>; Thomas Lee (thomas.lee@adph.state.al.us) <thomas.lee@adph.state.al.us>; Tiffany Vance (Tiffany.vance@arkansas.gov) <Tiffany.vance@arkansas.gov>; Tomas Aragon (Tomas.Aragon@sfdph.org) <Tomas.Aragon@sfdph.org>; Tracy Smith (tracy.smith2@alaska.gov) <tracy.smith2@alaska.gov>; Trang Nguyen (Trang.Nguyen@sfdph.org) <Trang.Nguyen@sfdph.org>; Travis O'Donnell (travis.odonnell@health.ny.gov) <travis.odonnell@health.ny.gov>; Valentina Adamova (Valentina.Adamova@health.ri.gov) <Valentina.Adamova@health.ri.gov>; Yesenia Mendez (acting) (yesenia.mendez@state.co.us) <yesenia.mendez@state.co.us>
Cc: Fuld, Jennifer (CDC/DDID/NCHHSTP/DSTDP) <ngt0@cdc.gov>; McFarlane, Mary (CDC/DDID/NCHHSTP/DSTDP) <xzm3@cdc.gov>; Carter, Marion (CDC/DDID/NCHHSTP/DSTDP) <acq0@cdc.gov>; Johnson, Britney (CDC/DDID/NCHHSTP/DSTDP) <mwq4@cdc.gov>; Johnson, Nina (CDC/DDID/NCHHSTP/DSTDP) <wvi3@cdc.gov>; Asamaowei, Tawanda (CDC/DDID/NCHHSTP/DSTDP) <lhy0@cdc.gov>; Davis, Cassandra (CDC/DDID/NCHHSTP/DSTDP) <vts4@cdc.gov>; Perri, Bianca (CDC/DDID/NCHHSTP/DSTDP) <ftn5@cdc.gov>
Subject: Reminder for STD Programs to Register Now! STD PCHD Kickoff Webinar on January 17, 2019 from 2:00PM--3:00PM Eastern Time

Reminder – looking forward to tomorrow's webinar.

Agenda items:

1. STD PCHD program support
2. STD AAPPS closeout information
3. STD PCHD application review process
4. Technical assistance planning
5. Dates to remember
6. Questions and Answers

Subject: Register Now! STD PCHD Kickoff Webinar on January 17, 2019 from 2:00PM--3:00PM Eastern Time

Hello STD PCHD recipients, and happy new year!

As announced previously, we will hold the STD PCHD Kickoff Webinar on January 17, 2019, from 2:00PM – 3:00PM Eastern Time. An agenda will be sent prior to the call.

Please register for the call at the following link:

Registration Link: <https://cc.readytalk.com/r/ma4sp95j4c9d&eom>

We look forward to speaking with you on January 17.

-Mary McFarlane on behalf of STD PCHD

Mary McFarlane, PhD
Program Development and Quality Improvement Branch
Division of STD Prevention
U.S. Centers for Disease Control and Prevention
1600 Clifton Road Mailstop E27
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404 639 8309 Phone
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xzm3@cdc.gov

Telework Tuesday / cell 404 226 9818

From: Halstenson, Gentle
Sent: 1/18/2019 1:49:46 PM
To: MacLeod, Kim (DOH)
Subject: RE: CD Epi Support for GCD - Clark County



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Hi Kim,

Thanks for reaching out, I also received your voicemail. I think the suggestions look great. For right now, I am the only one working on general CD so any help is appreciated.

If the team can implement working on number 2, that would be helpful, with just reviewing any new labs that come in for cases we already know about/ completed.

Also, number 3 would be very helpful. I can fax the paper labs in and that would save time if someone else could create the case, I can be working on the quick follow-up items (like PEP for a pertussis patient).

The other suggestion I have is for any campy and giardia cases. We typically don't investigate/interview due to limited resources unless the person is aged 5 or less. Could those be worked by someone at the state?

If we start on Tuesday that would be fine. I think those items would be great help (based on my current workload) but we can just touch base if it becomes more overwhelming next week, if you think that's reasonable.

What number would I fax the paper labs that come in to?

Let me know if you think this sounds acceptable-

Thank you for your help!

<<https://www.clark.wa.gov/>>

Gentle Halstenson, BSN RN
Public Health Nurse II
INFECTIOUS DISEASE

564.397.8182

<<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>>
<<https://twitter.com/ClarkCoWA>> <<https://www.youtube.com/user/ClarkCoWa/>>

From: MacLeod, Kim (DOH) [mailto:kim.macleod@doh.wa.gov]
Sent: Friday, January 18, 2019 1:39 PM
To: Halstenson, Gentle
Cc: Boysun, Mike (DOH)
Subject: FW: CD Epi Support for GCD - Clark County

Hi Gentle –

I just left you a voicemail as well – wanted to connect on how best we can support Clark with non-Measles investigations :-)

We came up with a couple of suggestions, and I was hoping to chat with you to see which of these (if any) might be helpful, or if you have other needs and ideas about how this might work best.

Proposal to support Clark with non-measles case investigation - UPDATED

1. NEW CASES - Clark Cases with no investigator assigned
 - a. Kim will assign these to the DOH investigators by disease area
2. COMPLETED CASES WITH NEW LAB - Clark cases that are completed, but new lab reports come in to be reviewed
 - a. Kim will assign these to the DOH investigator by disease area
3. MANUAL LABS - Clark can fax/email all their paper/manual lab reports and we will enter them in WDRS, either as new case or attaching to an existing case
4. STARTED CASES - Clark cases that are “in flight” with an investigator assigned – Clark can request assistance on a case-by-case basis

Open issues/questions:

- * We can do any/all of this, whatever works for Clark (or other tasks identified)
- * When do we want to start this?
- * Are there any condition-specific protocols?
- * Does Clark want to be aware of these investigations at all or be directly involved
- * Does Clark County have a COOP plan that might be able to guide prioritization of cases?

Please give me a call or email at your convenience to discuss – our Epis have been prepped and readied for support tasks once we’ve confirmed what we’ll be taking on .

Thanks,

Kim M

KIM MACLEOD
Data Support Unit Program Supervisor

Office of Communicable Disease Epidemiology
Division of Disease Control and Health Statistics
Washington State Department of Health
kim.macleod@doh.wa.gov
206-418-5646 | www.doh.wa.gov
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Gender Pronouns: she/her
<<https://www.doh.wa.gov/Newsroom/SocialMedia>>

From: Boysun, Mike (DOH)
Sent: Friday, January 18, 2019 1:05 PM
To: MacLeod, Kim (DOH) <kim.macleod@doh.wa.gov>
Subject: FW: CD Epi Support for GCD - Clark County

From: Czapla, Monica [mailto:Monica.Czapla@clark.wa.gov]
Sent: Friday, January 18, 2019 12:58 PM
To: Matheson, Jasmine S (DOH) <Jasmine.Matheson@DOH.WA.GOV>
Cc: Boysun, Mike (DOH) <Mike.Boysun@DOH.WA.GOV>; Harry, Cynthia S (DOH) <cynthia.harry@doh.wa.gov>; DOH-OSC (DOH) <doh-osc@doh.wa.gov>
Subject: RE: CD Epi Support for GCD - Clark County

Halstenson, Gentle <Gentle.Halstenson@clark.wa.gov>

<<https://www.clark.wa.gov/>>

Monica Czapla, MPH
Program Manager - Infectious Diseases
PUBLIC HEALTH

564.397.8002 (note: our office area code has changed)
360.836.9086 cell

<<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>>
<<https://twitter.com/ClarkCoWA>> <<https://www.youtube.com/user/ClarkCoWa/>>

From: Matheson, Jasmine S (DOH) [mailto:Jasmine.Matheson@DOH.WA.GOV]
Sent: Thursday, January 17, 2019 6:02 PM
To: Czapla, Monica
Cc: Boysun, Mike (DOH); Harry, Cynthia S (DOH); DOH-OSC (DOH)
Subject: CD Epi Support for GCD - Clark County

Hi Monica

Our office is able to assist in supporting GCD investigations for Clark County.

Points of contact:

- * VPD (non-measles outbreak): Amy Poel
- * Enterics: Beth Melius
- * Zoonotic Diseases: Hanna Oltean
- * Influenza/Legionella: Vivian Hawkins
- * Hepatitis B (acute): Marcia Goldoft
- * HAI: Sara Podczervinski

We are currently able to support creating cases in WDRS, investigation and public health actions and data entry. For each condition area it will be important to transition existing Clark County cases and establish any condition-specific protocols. Currently there are 19

open investigations in WDRS for Clark County. For new cases, we'll need to set up designated processes and address condition specific questions. For example, investigation of immediately notifiable conditions and public health actions – does Clark want to be aware of these investigations at all or be directly involved (e.g., prophylaxis)?

Does Clark County have a COOP plan that might be able to guide prioritization of cases?

If you could please connect Mike Boysun and Cynthia Harry to the best person from your staff to facilitate transition of GCD work, the subject matter leads can provide suggestions and jointly plan to ensure effective follow-up.

Thanks and see you tomorrow.
Jasmine

Jasmine Matheson, MPH
Program Manager / Refugee Health Coordinator
Disease Control and Health Statistics
Washington State Department of Health
jasmine.matheson@doh.wa.gov
206-418-5603 | www.doh.wa.gov
<<https://www.doh.wa.gov/Newsroom/SocialMedia>>

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This e-mail and related attachments and any response may be subject to public disclosure under state law.

From: EPIXUpdate@cdc.gov
Sent: 1/19/2019 2:05:51 AM
To: Close, Natasha (DOH)
Cc:
Subject: Epi-X Today: Saturday, January 19, 2019

Epi-X reports posted in your areas of interest in the past 24 hours. To view a specific report, click on its URL.

~ ~ ~ ~ ~

FSIS Class I Recall: Custom Made Meals, LLC Recalls Chicken Skewer Products Due to Misbranding and Undeclared Allergens - 2019
Custom Made Meals, LLC, a Denver, CO, establishment, is recalling approximately 7,954 pounds of chicken skewer products due to misbranding and undeclared allergens, the U.S. Department of Agriculture's FSIS announced today. The products contain coconut, a known tree nut allergen that is not declared on the product label.
<https://epix2.cdc.gov/v2/Reports/Display.aspx?id=69306>

~ ~ ~ ~ ~

FSIS Class I Recall: H & T Seafood, Inc. Recalls Siluriformes Products Produced Without Benefit of Import Inspection -- 2019
H & T Seafood, Inc., the Importer of Record, a Bell, Calif. firm, is recalling approximately 71,435 pounds of imported Siluriformes fish products because the products were not presented for import re-inspection upon entry into the United States, the U.S. Department of Agriculture's Food Safety and Inspection Service (FSIS) announced today.
<https://epix2.cdc.gov/v2/Reports/Display.aspx?id=69305>

~ ~ ~ ~ ~

CDC OSSAM PHIO International Disease Summary -- Multiple Nations, January 11-18, 2019
Diseases reported in this summary chikungunya in Thailand, measles in Vietnam and Taiwan, and deaths due to an unidentified illness in Argentina.
<https://epix2.cdc.gov/v2/Reports/Display.aspx?id=69302>

~ ~ ~ ~ ~

FSIS Class I Recall: Johnsonville, LLC Recalls Raw Ground Frozen Cheddar Cheese and Bacon Flavored Pork Patty Products Due to Possible Foreign Matter Contamination - 2019
Johnsonville, LLC, a Sheboygan Falls, Wis. establishment, is recalling approximately 48,371 pounds of raw ground pork patty products that may be contaminated with extraneous materials, specifically black rubber, the U.S. Department of Agriculture's Food Safety and Inspection Service (FSIS) announced today.
<https://epix2.cdc.gov/v2/Reports/Display.aspx?id=69301>

~ ~ ~ ~ ~

~*~ Global Immunization News Report, January 17, 2019 ~*~
Today's Global Immunization News report includes polio, measles, mumps, cholera, acute flaccid myelitis, policy and funding, vaccine demand and safety, and other news for Thursday, January 17, 2019.
<https://epix2.cdc.gov/v2/Reports/Display.aspx?id=69300>

~ ~ ~ ~ ~

Influenza Summary Update, Week Ending January 12, 2019 (Week 2) -- United States,

Influenza activity remains elevated in the U.S. The geographic spread of influenza in Guam and 30 states was reported as widespread; Puerto Rico and 16 states reported regional activity; three states reported local activity; and the District of Columbia, the U.S. Virgin Islands and one state reported sporadic activity.
<https://epix2.cdc.gov/v2/Reports/Display.aspx?id=69298>

Rabies Outbreak Investigation Dominican Republic and Haiti, 2019
EPI-2019-11: CDC has been requested to assist the Ministries of Health in Haiti and the Dominican Republic with a rabies outbreak investigation.
<https://epix2.cdc.gov/v2/Reports/Display.aspx?id=69304>

Media stories include possible tuberculosis in California and Guam, hepatitis A in multiple states; pertussis in Maine and Canada; possible Legionnaires' in Missouri; rabies in South Carolina; measles in Oregon and Washington; mumps in Ireland, Ebola in DRC; toxic fentanyl in Canada; and other media coverage.
<https://epix2.cdc.gov/v2/Reports/Display.aspx?id=69299>

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From: Wiesman, John (DOH)
Sent: 1/18/2019 3:37:00 PM
To: Wiesman, John (DOH)
Cc:
Subject: Measles Outbreak Update #1



attachments\908D2A8045DB4589_MeaslesUpdate1.pdf

Sent via bcc: due to large number of recipients.

Dear Clark County Delegation, Legislative Leadership, Health Care Committee Members,
and Governor's Executive Team–

You have likely heard that Clark County is experiencing an outbreak of measles, which is rapidly growing in size. As of Friday, January 18th, the current case count stands at 19 confirmed cases and 7 suspect cases. I will tell you that with the very large numbers of public places these persons with measles have been while they were infectious, I fully expect this to spread beyond Clark County and to go on for weeks to months.

Attached is the first of our updates to you that we hope you will find useful. It gives you:

- Information you and your constituents need to know
- Symptoms of measles
- Resources you can link to and resources you can give to others on your web sites, newsletters and other communications.

We plan to send you periodic updates as things change.

Your governmental public health workers at the local and state level are working incredibly hard to identify cases and prevent further spread. This is a huge challenge as it can take 7 to 14 days for people to show symptoms after exposure and people can be infectious 4 days before and after the appearance of the rash.

If you have further information needs, please reach out to us.

Thank you for your interest.

John Wiesman, DrPH, MPH
Gender Pronouns: He/Him/His
Secretary of Health
Washington State Department of Health
101 Israel Rd SE; MS: 47890
Tumwater, WA 98504-7890
jmwiesman@doh.wa.gov
360-236-4030 | www.doh.wa.gov
<<https://www.doh.wa.gov/Newsroom/SocialMedia>>



Measles Update

#1

January 18, 2019



Clark County is currently responding to a measles outbreak. The Washington State Department of Health is supporting our local health partner in our shared mission of reducing the spread and length of the outbreak. In addition to the dozens of staff dedicated to this event, we have deployed a team of epidemiologists to Clark County to assist with case and contact investigation, and database development

This outbreak is expanding quickly. DOH is coordinating with Oregon, Multnomah County, tribal partners, local health jurisdictions, federal partners, and vaccine distributors.

What your constituents need to know

- Measles is extremely contagious, and can be serious, especially for young children.
- The most effective way to prevent measles is by being fully immunized.
- People who suspect they have been exposed and have symptoms of measles, should call their health care provider **prior** to visiting the medical office to make a plan that avoids exposing others in the waiting room.

Symptoms

- Early symptoms seem similar to a bad cold.
- High fever, runny nose, and cough, followed by a rash that lasts 5 to 6 days.
- Possible red, watery eyes that are sensitive to light and be very tired.

More resources

- Current case count: <https://www.clark.wa.gov/public-health/measles-investigation>
- Measles in Washington <https://doh.wa.gov/measles>.
- Check immunization records online: <https://wa.myir.net/>
- Measles information for travelers: <https://www.cdc.gov/measles/travelers.html>
- CDC information on measles <https://www.cdc.gov/vaccines/vpd/mmr/public/index.html>
- Information on who should NOT be vaccinated <https://www.cdc.gov/>

John Wiesman DrPH, MPH

Secretary of Health | 360-236-4030

From: DOH PCH Immunize WA
Sent: 1/17/2019 11:19:00 AM
To: Dannen, Brianna,DOH PCH OICP Nurses,Cnty Health Immunizations
Subject: RE: mmr



attachments\6964B5F972C74973_image002.png

attachments\568C75E8693C4AD9_image001.png

Please let me know if you want me to work with providers on R/R from the IIS. We can do GoToTrainings.

Chrystal

From: Dannen, Brianna [mailto:Brianna.Dannen@clark.wa.gov]
Sent: Thursday, January 17, 2019 10:41 AM
To: DOH PCH OICP Nurses <ImmuneNurses@DOH.WA.GOV>; Cnty Health Immunizations <immunizations@clark.wa.gov>
Cc: Campbell, Michelle L (DOH) <michelle.campbell@doh.wa.gov>; DOH PCH Immunize WA <ImmunizeWA@doh.wa.gov>
Subject: RE: mmr

Trang,
Thank you! I was able to respond this morning. Currently we have not changed our recommendations locally, and children should still be immunized according to ACIP schedule. We will put out information if this gets big enough that our health officer wants to recommend immunizing early (but hopefully that will not happen!).

If you have additional input please feel free to share.
Thank you,
Brianna

From: DOH PCH OICP Nurses [ImmuneNurses@DOH.WA.GOV]
Sent: Thursday, January 17, 2019 8:12 AM
To: Dannen, Brianna; Cnty Health Immunizations
Cc: Campbell, Michelle L (DOH); DOH PCH Immunize WA; DOH PCH OICP Nurses
Subject: RE: mmr
Hello,

I don't want to overstep and answer Deanna if you prefer to provide the recommendations for your local providers. Please let us know how we can help in any way. Thanks!

Trang Kuss, RN, MN, MPH
Immunization Nurse Consultant
Prevention and Community Health
Washington State Department of Health
trang.kuss@doh.wa.gov
360-236-3760 | www.doh.wa.gov
360-878-2003 | 1-866-397-0337

<<https://www.doh.wa.gov/Newsroom/SocialMedia>>

From: DOH PCH Immunize WA
Sent: Thursday, January 17, 2019 7:59 AM

To: DOH PCH OICP Nurses <ImmuneNurses@DOH.WA.GOV>
Cc: Campbell, Michelle L (DOH) <michelle.campbell@doh.wa.gov>
Subject: FW: mmr
Importance: High

Questions!

From: Deanna Schreiber [mailto:dschreib@tvc.org]
Sent: Thursday, January 17, 2019 7:44 AM
To: 'Dannen, Brianna' <Brianna.Dannen@clark.wa.gov>; immunizations@clark.wa.gov
<immunizations@clark.wa.gov>; DOH PCH Immunize WA <ImmunizeWA@doh.wa.gov>
Subject: mmr
Importance: High

We are being asked by many parents if early vaccination if recommended dose 1 at age 6mo or dose 2 at age 3 years ect. What are the recommendations?

Deanna Schreiber
MA Lead CTC Pediatrics, Vancouver Clinic

360-397-3647 OFFICE
360-604-1774 FAX
501 SE 172nd Ave., Vancouver, WA 98684
Dschreib@tvc.org

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From: Flake, Marie D (DOH)

Sent: 1/17/2019 11:01:55 AM

To: Turner, Susan (DOHi), Black, Ryan (DOH), Bodden, Jaime (DOHi), Burkland, Anne (DOHi), Calder, Allegra (DOHi), Courogen, Maria (DOH), Davis, Michelle (DOH), Debolt, Meghan (DOHi), Delahunt, Regina (DOHi), Dzedzy, Ed (DOHi), Goelz, Mary (DOHi), Halvorson, Clark R (DOH), Joyner, Pama (DOH), Ketchel, Jeff (DOHi), Kirkpatrick, Vicki (DOHi), Lindquist, Scott W (DOH), Melnick, Alan (DOHi), Miller, Angi (DOH), Rohr Tran, Holly (DOHi), Schanz, Matt (DOHi), Schuler, Christopher (DOHi), Tammy Axlund, Wilson, Lyndia (DOHi), Windom, David (DOHi), Wolfe, Roxanne (DOHi), Worsham, Dennis (DOHi), York, Danette (DOHi)

Cc:

Subject: RE: FPHS TWG Meeting 1/18/19



attachments\085282BE96B04653_Full Functional Definitions Manua_PRDTOOL_NAMETOOLONG.docx

TWG,

I received 3 responses that agree with Ed's suggested language, so I have swapped that language into the attached draft (pages 32 & 42). There are no other changes to this draft. We will use this copy during tomorrow's meeting. Below I made a couple of responses to Susan's comments in blue. Talk to you all tomorrow. – marie

Summary of Proposed Changes to Functional Definitions – for discussion/approval by TWG on 1/18/19

- * Page 29, G (CD) 1 (Data) – b (Immunization Information System) – Centralized Activity; c, d, f – adding effort for data input, quality, educating providers.--Agree
- * Page 31, G (CD) 3 (Immunizations) & b – adding effort for promoting IIS and data input, quality, educating providers. Isn't the registry called the Washington IIS, or WIIS? Yes, good catch.
- * Page 32, G (CD) 4 (Investigation) d – adding efforts to collect, package, ship and test CD samples; e – receive case reports from providers, labs and other reporters. In 4d recommend adding "package" between "...specimens," and "ship,"—thanks for adding "other reporters to 4.e.
- * Page 34, G (CD) 5 (PHL) – Centralized Activity with support from PHSKC—Agree with changes, and agree with comment in margin that 24/7 COOP for LHJs to reach the lab and send specimens is covered in G.4.k.
- * Page 41 & 42, I (EH) 3 (Investigations) – adding efforts to collect, package, ship and test EH samples—Page 42 G.3.j. needs to have "package" added as in the third bullet above
- * Page 47, J (MCH) 3 (Newborn screening) – Centralized Activity--Agree
- * Page 50, K (Access) 3 (Licensing) – Centralized Activity--Agree
- * Page 52, L (VR) 1 (Data system) – Centralized Activity—Agree IF DOH is the only entity that does all of the functions (don't locals do L.1.d., e. f. g?)—also one thing I don't see is any local review of birth/death records for surveillance. Not sure LHJs do this, but I have heard rumors about Health Officers wanting to be informed for suspicious causes of death that represent public health threats, especially as relates to several proximate deaths due to one cause, infant and child deaths, or environmental threats. I don't know

whether the TWG ever talked about that as an FPHS...

The intent of L1 is to capture the centralized activities involved in providing and maintaining the vital records data system and turning the records into vital statistics data and sharing it. The intent of L2 is to capture the activities involved using the vital records system and issuing certificates. Accessing, analyzing and using (surveillance) vital statistics data is captured in A 2 (Assessment, pg 14).

From: NCIRD Immunization Grantee Mailbox (CDC)
Sent: 1/17/2019 7:06:39 AM
To: NCIRD Immunization Grantee Mailbox (CDC)
Subject: Vaccine Planning: Inventory/Advanced Bulk Purchase Update 1.17.19



*attachments\65B94F8BED4A49AF_1-17-19 Vaccine Inventory
Advanc_PRDTool_NAMETOOLONG.xlsx*



*attachments\AC714D88D8134EA3_1-17-19 Vaccine Inventory
Advanc_PRDTool_NAMETOOLONG.pdf*



attachments\DB88E94B83E74381_image001.jpg

Please see the latest inventory update below

Vaccine Inventory Update

1/17/2019

Last Update	Vaccine	Manufacturer	Brand	NDC Number	Presentation	UPDATE	ACTION	Alternative Products
1/17/2019	Hep B (Adult)	GSK	Engerix-B	58160-0821-52	10 pack - 1 dose syringe	Currently available in both DCs	NONE	NONE
1/16/2019	DTaP-IPV (Pediatric)	GSK	Kinrix	58160-0812-11	10 pack - 1 dose vial	Currently out of inventory in Memphis only	Please cancel all backorders. This product is no longer on the CDC contracts	58160-0812-52
12/3/2018	Hep A (Pediatric)	GSK	Havrix	58160-0825-11	10 pack - 1 dose vial	Currently out of inventory in both DCs	Please cancel all backorders. This product is no longer on the CDC contracts	58160-0825-52
To cancel orders, please contact McKesson: CDCCustomerService@McKesson.com						REMINDER: Based on the information in this table, ExIS awardees may need to update the list of NDCs in their ExIS (e.g., by manual entry into their ExIS or uploading the latest VTrckS federal vaccines list to their ExIS). Contact the Vaccine Order Management Contact Center if you encounter problems with this activity: 1-877-878-6247 or vaccineordermgmt@cdc.gov .		
For vaccine inventory questions, please email: vaccinedistributionc@cdc.gov								

A green row signifies the addition of a product without any inventory issue.

Rows with no color signify a product with a depleted inventory or an inventory issue and alert you that action may need to be taken on your part.

Advance Bulk Purchase Update
Note:

The NDCs listed below are **currently not available** for placing bulk orders on the CDC contracts.
Please contact your Vaccine Advisor for information about alternative products available for bulk order.

58160-0812-11 (PEDIATRIC) GSK Kinrix
 58160-0812-52 (PEDIATRIC) GSK Kinrix
 58160-0815-52 (PEDIATRIC & ADULT) GSK Twinrix
 58160-0818-11 (PEDIATRIC) GSK Hiberix
 58160-0823-11 Zoster (ADULT) GSK Shingrix
 58160-0819-12 Zoster (ADULT) GSK Shingrix
 58160-0820-52 Hep B (PEDIATRIC) GSK Engerix B
 58160-0825-11 (PEDIATRIC) GSK Havrix
 58160-0826-52 Hep A (ADULT) GSK Havrix
 00006-4841-41 Hep A (ADULT) Merck Vaxta
 00006-4096-02 Hep A (ADULT) Merck Vaxta
 00006-4981-00 Hep B (PEDIATRIC) Merck Recombivax HB
 00006-4093-02 Hep B (PEDIATRIC) Merck Recombivax HB
 00006-4094-02 Hep B (ADULT) Merck Recombivax HB
 00006-4995-41 Hep B (ADULT) Merck Recombivax HB

HOW TO CONTACT Epi-X

For technical issues, contact the Help Desk:

EpiXHelp@cdc.gov

(877) 438-3749

For help with preparing or posting a report, contact the Editor on Call:

(877) 862-2392 (toll free within the United States)

+1-770-488-7100 (If you cannot use the toll free number above, please call the CDC Emergency Operations Center and ask to speak to the Epi-X editor on call.)

IMPORTANT REMINDERS

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Receive this message in Text format: <https://epix2.cdc.gov/v2/Preferences.aspx#Email>

From: Matheson, Jasmine S (DOH)
Sent: 1/17/2019 6:02:26 PM
To: Czapla, Monica
Subject: CD Epi Support for GCD - Clark County



attachments\4810EF862CEB48E4_image003.png

Hi Monica

Our office is able to assist in supporting GCD investigations for Clark County.

Points of contact:

- * VPD (non-measles outbreak): Amy Poel
- * Enterics: Beth Melius
- * Zoonotic Diseases: Hanna Oltean
- * Influenza/Legionella: Vivian Hawkins
- * Hepatitis B (acute): Marcia Goldoft
- * HAI: Sara Podczervinski

We are currently able to support creating cases in WDRS, investigation and public health actions and data entry. For each condition area it will be important to transition existing Clark County cases and establish any condition-specific protocols. Currently there are 19 open investigations in WDRS for Clark County. For new cases, we'll need to set up designated processes and address condition specific questions. For example, investigation of immediately notifiable conditions and public health actions – does Clark want to be aware of these investigations at all or be directly involved (e.g., prophylaxis)?


Does Clark County have a COOP plan that might be able to guide prioritization of cases?

If you could please connect Mike Boysun and Cynthia Harry to the best person from your staff to facilitate transition of GCD work, the subject matter leads can provide suggestions and jointly plan to ensure effective follow-up.

Thanks and see you tomorrow.
Jasmine

Jasmine Matheson, MPH
Program Manager / Refugee Health Coordinator
Disease Control and Health Statistics
Washington State Department of Health
jasmine.matheson@doh.wa.gov
206-418-5603 | www.doh.wa.gov
<<https://www.doh.wa.gov/Newsroom/SocialMedia>>

From: MacLeod, Kim (DOH)
Sent: 1/18/2019 2:36:57 PM
To: Halstenson, Gentle
Subject: RE: CD Epi Support for GCD - Clark County

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 *attachments\4FB351E709954FA4_image015.jpg*
 *attachments\A2BBD5BB8EA14A77_image006.jpg*
 *attachments\70E97CA39A2544BC_image017.png*
 *attachments\D63DDCFB8D0E4F76_image011.jpg*
 *attachments\898C7264D04347F1_image008.jpg*
 *attachments\A5048F2EA24B4025_image014.jpg*
 *attachments\F6FD06393CF74E81_image002.png*
 *attachments\06E4A7F1B3F04E64_image012.png*
 *attachments\AC0600E5381443CD_image016.jpg*
 *attachments\0D2FBF432F6A453B_image010.jpg*

Hi Gentle – thanks for the quick turn around on this! We're happy to help any way we can.

Let's start with this for Tuesday, and we can re-assess if there's more/less you would like us to do later in the week?

1. NEW CASES - Clark Cases with no investigator assigned for CAMPY and GIAR only, aged 5 or less only
 - a. Kim will assign these to the FB Epis for investigation/interview
2. COMPLETED CASES WITH NEW LAB - Clark cases that are completed, but new lab reports come in to be reviewed
 - a. Kim will assign these to the DOH investigator by disease area for review
3. MANUAL LABS - Clark can fax/email all their paper/manual lab reports and we will enter them in WDRS, either as new case or attaching to an existing case.
 - a. Please fax to 206-362-2486, attn.: Kim MacLeod

Let me know if this looks good, and we'll plan on starting here!

Thanks,

Kim M

KIM MACLEOD
Data Support Unit Program Supervisor
Office of Communicable Disease Epidemiology
Division of Disease Control and Health Statistics

Washington State Department of Health
kim.macleod@doh.wa.gov
206-418-5646 | www.doh.wa.gov
206-418-5500 | Fax- 206-364-1060
Gender Pronouns: she/her
<<https://www.doh.wa.gov/Newsroom/SocialMedia>>

From: Halstenson, Gentle [mailto:Gentle.Halstenson@clark.wa.gov]
Sent: Friday, January 18, 2019 1:50 PM
To: MacLeod, Kim (DOH) <kim.macleod@doh.wa.gov>
Cc: Boysun, Mike (DOH) <Mike.Boysun@DOH.WA.GOV>
Subject: RE: CD Epi Support for GCD - Clark County

Hi Kim,

Thanks for reaching out, I also received your voicemail. I think the suggestions look great. For right now, I am the only one working on general CD so any help is appreciated.

If the team can implement working on number 2, that would be helpful, with just reviewing any new labs that come in for cases we already know about/ completed.

Also, number 3 would be very helpful. I can fax the paper labs in and that would save time if someone else could create the case, I can be working on the quick follow-up items (like PEP for a pertussis patient).

The other suggestion I have is for any campy and giardia cases. We typically don't investigate/interview due to limited resources unless the person is aged 5 or less. Could those be worked by someone at the state?

If we start on Tuesday that would be fine. I think those items would be great help (based on my current workload) but we can just touch base if it becomes more overwhelming next week, if you think that's reasonable.

What number would I fax the paper labs that come in to?

Let me know if you think this sounds acceptable-

Thank you for your help!

<<https://www.clark.wa.gov/>>

Gentle Halstenson, BSN RN
Public Health Nurse II
INFECTIOUS DISEASE

564.397.8182

<<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>>
<<https://twitter.com/ClarkCoWA>> <<https://www.youtube.com/user/ClarkCoWa/>>

From: MacLeod, Kim (DOH) [mailto:kim.macleod@doh.wa.gov]
Sent: Friday, January 18, 2019 1:39 PM
To: Halstenson, Gentle
Cc: Boysun, Mike (DOH)

Subject: FW: CD Epi Support for GCD - Clark County

Hi Gentle –

I just left you a voicemail as well – wanted to connect on how best we can support Clark with non-Measles investigations :-)

We came up with a couple of suggestions, and I was hoping to chat with you to see which of these (if any) might be helpful, or if you have other needs and ideas about how this might work best.

Proposal to support Clark with non-measles case investigation - UPDATED

1. NEW CASES - Clark Cases with no investigator assigned
 - a. Kim will assign these to the DOH investigators by disease area
2. COMPLETED CASES WITH NEW LAB - Clark cases that are completed, but new lab reports come in to be reviewed
 - a. Kim will assign these to the DOH investigator by disease area
3. MANUAL LABS - Clark can fax/email all their paper/manual lab reports and we will enter them in WDRS, either as new case or attaching to an existing case
4. STARTED CASES - Clark cases that are “in flight” with an investigator assigned – Clark can request assistance on a case-by-case basis

Open issues/questions:

- * We can do any/all of this, whatever works for Clark (or other tasks identified)
- * When do we want to start this?
- * Are there any condition-specific protocols?
- * Does Clark want to be aware of these investigations at all or be directly involved
- * Does Clark County have a COOP plan that might be able to guide prioritization of cases?

Please give me a call or email at your convenience to discuss – our Epis have been prepped and readied for support tasks once we’ve confirmed what we’ll be taking on .

Thanks,

Kim M

KIM MACLEOD
Data Support Unit Program Supervisor
Office of Communicable Disease Epidemiology
Division of Disease Control and Health Statistics
Washington State Department of Health
kim.macleod@doh.wa.gov
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Gender Pronouns: she/her
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From: Boysun, Mike (DOH)
Sent: Friday, January 18, 2019 1:05 PM
To: MacLeod, Kim (DOH) <kim.macleod@doh.wa.gov>
Subject: FW: CD Epi Support for GCD - Clark County

From: Czapla, Monica [mailto:Monica.Czapla@clark.wa.gov]
Sent: Friday, January 18, 2019 12:58 PM
To: Matheson, Jasmine S (DOH) <Jasmine.Matheson@DOH.WA.GOV>
Cc: Boysun, Mike (DOH) <Mike.Boysun@DOH.WA.GOV>; Harry, Cynthia S (DOH) <cynthia.harry@doh.wa.gov>; DOH-OSC (DOH) <doh-osc@doh.wa.gov>
Subject: RE: CD Epi Support for GCD - Clark County

Halstenson, Gentle <Gentle.Halstenson@clark.wa.gov>

<<https://www.clark.wa.gov/>>

Monica Czapla, MPH
Program Manager - Infectious Diseases
PUBLIC HEALTH

564.397.8002 (note: our office area code has changed)
360.836.9086 cell

<<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>>
<<https://twitter.com/ClarkCoWA>> <<https://www.youtube.com/user/ClarkCoWa/>>

From: Matheson, Jasmine S (DOH) [mailto:Jasmine.Matheson@DOH.WA.GOV]
Sent: Thursday, January 17, 2019 6:02 PM
To: Czapla, Monica
Cc: Boysun, Mike (DOH); Harry, Cynthia S (DOH); DOH-OSC (DOH)
Subject: CD Epi Support for GCD - Clark County

Hi Monica

Our office is able to assist in supporting GCD investigations for Clark County.

Points of contact:

- * VPD (non-measles outbreak): Amy Poel
- * Enterics: Beth Melius
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- * Influenza/Legionella: Vivian Hawkins
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Thanks and see you tomorrow.
Jasmine

Jasmine Matheson, MPH
Program Manager / Refugee Health Coordinator
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From: Poel, Amy J (DOH)
Sent: 1/15/2019 4:10:03 PM
To: Carlson, Alyssa (DOHi), Halstenson, Gentle, Czapla, Monica, Riethman, Madison (DOHi)
Subject: CD Epi Measles contact



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attachments\A03D261D19A947D0_image004.png



attachments\73B243F9C56F4208_image002.png



attachments\0CD3385B4F194332_image008.png

Hello all,

So that you will have excellent dedicated support here in CD Epi, Soyeon Lippman is going to take over for me as the person handling the DOH measles linelist, coordinating measles specimen testing, communicating measles lab testing results to you, and doing anything else you may need here from CD Epi. She will be performing these tasks M-R all day and Friday until noon. You can contact me after noon on Friday. You can reach her at the above e-mail or call her directly at 206-418-5590.

I will be handling all of the other VPD's (AFM, pertussis, diphtheria, tetanus, mumps, rubella, mening, h flu, varicella) and will be in the office and reachable through phone and email.

Amy

Amy J. Poel
Epidemiologist/Vaccine Preventable Disease Coordinator
Office of Communicable Disease Epidemiology
Division of Disease Control and Health Statistics
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Fax 206-364-1060
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<<https://www.facebook.com/WADeptHealth/>>
<<https://www.instagram.com/wadepthealth/>>
<<https://www.youtube.com/channel/UCTSCpezTD0TjiiAOuJY7f5w/doh>>
<<https://medium.com/@WADeptHealth>>

From: Verell, Dale (CDC/DDID/NCIRD/ISD) (CTR)

Sent: 1/16/2019 6:28:27 AM

To: Abbi Berg, Adrienne Mercadel Whitney, Alexandra Hayes, Alexandra Rexrode, Alice Morelos, Alicia Wieber, Alvarez, Veronica (CDC/DDID/NCIRD/ISD), Amanda Lascala, Amanda Orr, Amber Dorsey, Amber Tirmal, Amiee Stafford, Metroka, Amy (CDC health.nyc.gov), Amy Snyder, Angel Lapaz, Rivera, Angel (CDC salud.gov.pr), Angela Rhoades, Aguon, Annette L (CDC dphss.guam.gov), Annie Giangardella, Annie Peterson-Lewis, Arianne Ramautar, Arnese Dickens, Ashley Lankins, Elias, Augustus (CDC fsmhealth.fm), Mitchell, Becky (DOH), Becky Prall, Wehner, Bekki (CDC mt.gov), Ben Sloat, Beth Miller, Kintigh, Bethany (CDC idph.iowa.gov), Bill Ledford, Bradley Carpenter, Brandon Brown, Brandy Popely, Brandy Tidwell, Brenda Jaco, Brenda Snelson, Napier, Brian (CDC odh.ohio.gov), Brittani Ray, Candace Weathersby, Caroline Helton, Carolyn Parry, Carrie Tuggle, Apaisam, Carter (CDC fsmhealth.fm), Haralson, Catherine (CDC tn.gov), Cecile Town, Chalise Whitehead, Charles (Chuck) Wiley, Charles Lomae, Charma Miller, Chayanne Miranda, Cheryl Pascal, Chevonne Tyner, Chinenye Boyer, Christian Robles, Christina Montagano, Christina Sapad, Christine Wilson, Christopher T. Robinson, Christy Scheidler, Chrystal Gasowski, Findley, Cynthia (CDC pa.gov), Clarett Matlab, Clarissa Goode, Claudia Aguiluz, Claudia Soprano, Colleen Haggerty, Collette Lozoff, Courtney Williamson, Crista Sullivan, Cristi Chambers, Crystal Alderman, James, Crystal N (DOH), Pedro, Daisy (CDC gmail.com), Dan Ferrazzano, Goode, Dana (CDC azdhs.gov), Dana Mack-Marcus, Daniel Castillo, Daniel Lawlor, Danielle Sherwood, Darcy Wildt, Dave Feltz, McCormick, Dave (CDC isdh.in.gov), David Decker, Debbie Marote, Deborah Hindman, Deborah Sennett, Debra Zambrano, Denise Strickland, Herrero, Diana (CDC state.co.us), Diane Romnes, Dileep Sarecha, DirraLukes Ngiraboi, Don Callaghan, Donna McKean, Donna S. McNeil, Dr. Marielle Fricchione, Easter Leofili, Anzures, Edlen (CDC gmail.com), Elaine Pherigo, Elizabeth Cisneros, Erica Davis, Erin Corrigan, Caniglia, Frank (CDC pa.gov), Frank Hill, GA VFC, Gabriela Lemus, Gary Miller, Gina Lathan, Glenn Witt, Gloria Ramon, Grace Cooper, Reed, Greg (CDC maryland.gov), Olliges, Hailey M (DOH), Halima Dumas, Roth, Heather (CDC state.co.us), Heather Winfield-Smith, Herokko Neamon, Ida Taylor, Ines Burazerovic, Ivette Maldonado Garcia, Stockdale, Jacki (DOH), Jackie Strecker, Jackolyn James, Jacob Mbafor, James Cobb, Lutz, James (Philadelphia) (CDC phila.gov), Jamie Hale, Janean Iddings, Jorgenson, Janel (DOH), Jason Hien, Jeffrey Sablan, Jenne McKibben, Jennifer Green, Jennifer King, Jennifer Paulk, Jennifer Yara-Zelenski, Jenny Bilbro, Sasamoto, Jeremy (CDC gmail.com), Jill King, Jilliam Brown, Talbott, James (CDC state.de.us), Jimekia Jackson, Schweitzer, Jody (CDC ky.gov), John Gotschalk, Joseph, John (CDC odh.ohio.gov), John Khoury, Jose Guzman Pereira, Josette Ono, Alden, Jude (CDC wyo.gov), Lasch, Julianne (DOH), Nannini, Julie (DOH), Juliet Jumila, Kaleisha Blount, Kara Connelly, Karen Bolander, Karen Halverson, Karen Pendergrass, Karen Rutherford, Karen Tsuyuki, Kate Dauber, Kathleen Shattuck, Kudish, Kathy (CDC ct.gov), Katie Grady-Selby, Katie Martinez, Kayla Boykins, Kayleigh Davis, Kelsey Pistotnik, Kevin Hansen, Kim Salisbury-Keith, Kim Wehmeyer, Kimberly Gierla, Kisha Wiggins, Kristy Royalty, Kristy Westfall, Seeto, Kurt (CDC maryland.gov), Kyle Wildt, Landon Decherong, Laura Harrod, Laura Ogo, Laurie Anderson, Leisa Spence, Lena Boulanger, Leone Jackson, Linda Kasebier, Lisa Dunn, Lisa Moffatt, Lori Hutchinson, Lori Johnson, Lorraine Alfsen, Helgenberger, Louisa (CDC fsmhealth.fm), Lucio Hidemi, Lucy Cosgrove, Lynette Hanson, Lynn Jones, Lynne Padilla-Trujillo, Trefren, Lynn (CDC state.co.us), Marc Digirolamo, Margaret Foulise, Maria Cuoghi, Maria Heinz, Maria McGinnis, Mariean Kliu Kazuma, Mark Francesconi, Mark Ritter, Huynh, Mary B. (CDC/DDID/NCIRD/ISD), Matthew Bobo, Meagan Surgenor, Deming, Megan (DOH), Miller, Megan (CDC sanantonio.gov), Melinda Johnson, Melisa Mickle-Hope, Couture, Melissa (DOH), Melissa Ferrell, Basilius, Merlyn (CDC gmail.com), Michael (Mick) Bolduc, Michael Dougherty, Michael L. Allen, Michele S. Leon Guerrero, Mimi Luther, Miranda Baumgartner, Missy Brown, Misty Pickner, Paris, Mitchell J (DOH), Montique Shepherd, Nancy Rosenthal, Hartert, Nathalie (CDC tn.gov), Lee, Nick (DOH), Nicole Ortiz, Pamela Forest, Pat Carter, Patricia Deyo, Patrick Loftus, Paula Doan, Pauline Brantley-Hobbs, Peggy Cook, Talebian, Pejman (CDC state.ma.us), Judicpa, Pedro (Peter) (CDC/DDID/NCIRD/ISD), Poonam Mahajan, Rachael Miles, Rattana Bip, Renee Smith, Rex

Larsen, Richard Carney, Rita Lathrem, Rita Oliva, Robert Starszak, Robin Cahall, Robin Holding, Roland Irons, Ron Ferencz, Balajadia, Ronald (CDC doh.hawaii.gov), Rosario Velez Santana, McLaren, Rosie (CDC dc.gov), Salustia Mira, Samantha Griego, Sarah Moore, De Leon, Renee Sasha (DOH), Savannah Benevidez, Bennett, Shannon (CDC health.nv.gov), Sharon Kasper, Allen, Sheanne (DOH), Lovett, Sheila (CDC dph.ga.gov), Sheila Piper, Shelby Williams, Sherell Stevens-Masten, Sheryl Proulx, Shumethia Seal (shumethia.a.seal@state.ma.us), deFijter, Sietske (CDC odh.ohio.gov), White, Stephen (CDC dhec.sc.gov), Sue Duggan-Ball, Sue Flavin, Susan Kocen, Suzee Moore, Tamara Carr, Tamarie Olson, Tammy S. Brown, Teneale Chapton, Teresa Brumbley, Nicholson, Teri (CDC illinois.gov), Terrance Paulson, Thomas McCleaf, Thomas Young, Tim Barnes, Heath, Tim (CDC state.sd.us), Tina Patterson, Philbrick, Tonya (CDC maine.gov), Hull, Torane (CDC dhhs.nh.gov), Washburn, Tricia (CDC health.ri.gov), Trish Stowe, Shoshtarikj, Valentin (CDC azdhs.gov), Victor Chongwa, Victoria McIntyre, Violet I, Wendell Gullede, Montano Lopez, Wendy (DOH), Wendy Sweigert, Masunu, Yolanda (CDC gmail.com), Zachary Runkle

Cc:

Subject: FW: Vaccine Planning: Inventory/Advanced Bulk Purchase Update 1.16.19



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attachments\BB24F8B380FB4BDA_1-16-19 Vaccine Inventory Advanc_PRDTool_NAMETOOLONG.xlsx



attachments\651009D10A544B71_1-16-19 Vaccine Inventory Advanc_PRDTool_NAMETOOLONG.pdf

Please read.

From: NCIRD Immunization Grantee Mailbox (CDC) <nipgrant@cdc.gov>
Sent: Wednesday, January 16, 2019 8:54 AM
To: NCIRD Immunization Grantee Mailbox (CDC) <nipgrant@cdc.gov>
Cc: Santoli, Jeanne (CDC/DDID/NCIRD/ISD) <zmd4@cdc.gov>; Whitlatch, Frank (CDC/DDID/NCIRD/ISD) <cmn8@cdc.gov>; Tropper, Jeanne (CDC/DDID/NCIRD/ISD) <jwu0@cdc.gov>; Galloway, Lisa (CDC/DDID/NCIRD/ISD) <lfg8@cdc.gov>; Noblit, Cameron B. (CDC/DDID/NCIRD/ISD) <bsf4@cdc.gov>; Faas, Ashley (CDC/DDID/NCIRD/ISD) <kka2@cdc.gov>; Arneson, Kayla (CDC/DDID/NCIRD/ISD) <xkg1@cdc.gov>; Verell, Dale (CDC/DDID/NCIRD/ISD) (CTR) <ddv1@cdc.gov>
Subject: Vaccine Planning: Inventory/Advanced Bulk Purchase Update 1.16.19

Please see the latest inventory update below

Vaccine Inventory Update
1/16/2019

Last Update	Vaccine	Manufacturer	Brand	NDC Number	Presentation	UPDATE	ACTION	Alternative Products
1/16/2019	Hep B (Adult)	GSK	Engerix-B	58160-0821-52	10 pack - 1 dose syringe	Currently out of inventory in Aurora only Anticipated re-supply 1-2 weeks	Contact McKesson Customer Care if you wish to have your backorders cancelled	58160-0821-11
1/16/2019	DTaP-IPV (Pediatric)	GSK	Kinrix	58160-0812-11	10 pack - 1 dose vial	Currently out of inventory in Memphis only	Please cancel all backorders. This product is no longer on the CDC contracts	58160-0812-52
12/3/2018	Hep A (Pediatric)	GSK	Havrix	58160-0825-11	10 pack - 1 dose vial	Currently out of inventory in both DCs	Please cancel all backorders. This product is no longer on the CDC contracts	58160-0825-52

To cancel orders, please contact McKesson: CDCCustomerService@McKesson.com						REMINDER: Based on the information in this table, ExIS awardees may need to update the list of NDCs in their ExIS (e.g., by manual entry into their ExIS or uploading the latest VTrckS federal vaccines list to their ExIS).		
For vaccine inventory questions, please email: vaccinedistributionc@cdc.gov						Contact the Vaccine Order Management Contact Center if you encounter problems with this activity: 1-877-878-6247 or vaccineordermgmt@cdc.gov .		

A green row signifies the addition of a product without any inventory issue.

Rows with no color signify a product with a depleted inventory or an inventory issue and alert you that action may need to be taken on your part.

Advance Bulk Purchase Update

Note:
 The NDCs listed below are **currently not available** for placing bulk orders on the CDC contracts.
 Please contact your Vaccine Advisor for information about alternative products available for bulk order.

58160-0812-11 (PEDIATRIC) GSK Kinrix
 58160-0812-52 (PEDIATRIC) GSK Kinrix
 58160-0815-52 (PEDIATRIC & ADULT) GSK Twinrix
 58160-0818-11 (PEDIATRIC) GSK Hiberix
 58160-0823-11 Zoster (ADULT) GSK Shingrix
 58160-0819-12 Zoster (ADULT) GSK Shingrix
 58160-0820-52 Hep B (PEDIATRIC) GSK Engerix B
 58160-0825-11 (PEDIATRIC) GSK Havrix
 58160-0826-52 Hep A (ADULT) GSK Havrix
 00006-4841-41 Hep A (ADULT) Merck Vaaqa
 00006-4096-02 Hep A (ADULT) Merck Vaaqa
 00006-4981-00 Hep B (PEDIATRIC) Merck Recombivax HB
 00006-4093-02 Hep B (PEDIATRIC) Merck Recombivax HB
 00006-4094-02 Hep B (ADULT) Merck Recombivax HB
 00006-4995-41 Hep B (ADULT) Merck Recombivax HB

From: Shafar, Lindsey
Sent: 1/18/2019 12:54:55 PM
To: Cleveland, Annette, Winters, Vickie, Stonier, Monica, 'sarah.kohout@leg.wa.gov', Wylie, Sharon, 'Walsh, Megan', Wilson, Lynda, Hardtke, Amber (GMB), Harris, Paul, 'toni.camp@leg.wa.gov', Kraft, Vicki, 'tori.benson@leg.wa.gov', Rivers, Ann, Nelson, Michael, Vick, Brandon, Gilmour, Peter (GMB), Hoff, Larry, Quiring, Eileen, Blom, John, Lentz, Temple, Olson, Julie (Councilor), Hennessee, Shawn
Subject: RE: Clark County measles outbreak - visit with Secretary of Health TOMORROW



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CORRECTION – the meeting is Tomorrow, Saturday January 19th.

From: Shafar, Lindsey
Sent: Friday, January 18, 2019 12:48 PM
To: 'annette.cleveland@leg.wa.gov'; 'Winters, Vickie'; 'monica.stonier@leg.wa.gov'; 'sarah.kohout@leg.wa.gov'; 'Wylie, Rep. Sharon'; 'Walsh, Megan'; 'Wilson, Sen. Lynda'; Hardtke, Amber; 'paul.harris@leg.wa.gov'; 'toni.camp@leg.wa.gov'; 'vicki.kraft@leg.wa.gov'; 'tori.benson@leg.wa.gov'; 'ann.rivers@leg.wa.gov'; 'michael.nelson@leg.wa.gov'; 'Vick, Rep. Brandon'; Gilmour, Peter; 'larry.hoff@leg.wa.gov'; Quiring, Eileen; Blom, John; Lentz, Temple; Olson, Julie (Councilor); Hennessee, Shawn
Cc: DOH Secretary's Office; Hennessee, Shawn; Armstrong, Marissa; Bergener, Terry (DOH); 'Wiesman, John (DOH)'; Melnick, Alan; Gherman, Lydia
Subject: Clark County measles outbreak - visit with Secretary of Health TOMORROW
Importance: High

Good afternoon,

As you know, the Clark County Public Health Department is currently in the midst of responding to a measles outbreak in Clark County. Of course, responding to disease outbreaks is a primary part of foundational public health services.

In your role as a legislator, you play a key role in the current discussions regarding foundational public health. Secretary of Health Dr. John Wiesman will be in Clark County tomorrow, and he and Clark County Public Health Officer Dr. Alan Melnick would like to invite you and our Board of Health to an information session on the current status of the measles outbreak, the public health work that is being done, and what the next steps will be. This meeting will be:

Tomorrow, Saturday, January 26th
2:30 PM

Center for Community Health, 1601 East Fourth Plain Blvd in Vancouver. It is Building 17, near the VA.

If you are unable to attend in person, please let Lydia Gherman know (Lydia.gherman@clark.wa.gov) and she will get you conference call information.

As always, if you have questions, please let me know.

Thanks!

Lindsey

Lindsey Shafar
Senior Policy Analyst – Clark County Council
COUNTY MANAGER'S OFFICE
564.397.4157

<<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>>
<<https://twitter.com/ClarkCoWA>> <<https://www.youtube.com/user/ClarkCoWa/>>

This e-mail and related attachments and any response may be subject to public disclosure under state law.

From: Leja, Vanessa R (DOH)

Sent: 1/18/2019 10:49:25 AM

To: Adrian Aguilar-Perez, Jasmine Gruenstein, Jason Sterne, Nicotra, Jonas (DOHi), Joseph Ready, Jsani Henry, Billings, Judith (DOHi), Brown, Kathy (DOHi), Lara Strick, Fanning, Lauren (DOHi), Benevides, Maria (DOHi), Matt Golden, Melissa Roberts, Mike Barry, Price, Nicole (DOHi), Bertani, Scott (DOHi), Shauna Applin, Shireesha Dhanireddy, Jaenicke, Tom (DOH), abcmumford@gmail.com, Aidam

Mengis, aidsoutreach@hotmail.com, alisa@nasen.org, Hurley, Amanda

(DOHi), andreawilliams.rn@gmail.com, Ann Bruce, Aric

Lane, Bob@familycareofkent.com, Brian Davis (Merck), brianogary@gmail.com, Brie

Colangelo, Peters, Candice Y (DOH), Carie.a.harter@viivhealthcare.com, Daniel

Schollaert, danielleaskini@gmail.com, Dennis Torres, Director@san-nw.org, Duane

Wilkerson (eltond6602@gmail.com), Seelbach, Erick (DOHi), George

Bacon, highmountainranch@gmail.com, hitchcok@cwu.edu, james.matteucci@merck.com, Feldman,

Jason D (DOH), jgetz@eagles.ewu.edu, Joshua H. Behn, jsaintbart@icloud.com, Briddell,

Kate (DOHi), keri.a.smith@viivhealthcare.com, klarson@wship.org, Koch, Janis

(DOHi), Kristen Tjaden, Kristina Hermach

<kristina.hermach@comcast.net>, ktwest25@yahoo.com, kyledav@uw.edu, Dils,

Laurie, Cervantes, Lorenzo (DOHi), Levenson, Cheri I

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Gravelle, Kerr, Marcee (DOHi), Marissa Cruz <marissagcruzrn@gmail.com>, Garrett, Mark

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Feldman, Paul LaKosky, Ray Dumas, Robinson, Karen L

(DOH), rodd.marcum@us.army.mil, rosti@comcast.net, sewallac@fredhutch.org

, shilo@peoplesharmreductionalliance.org, susys@bfhd.wa.gov, Teresa Fries, Koester, Tony

(DOHi), Wakefield, Steven F

<swakefield@fredhutch.org>, walshb@uw.edu, waryap@NHWA.ORG, Wendy

Nakatsukasa=Ono, Hansen, Will (DOHi)

Subject: HPSG PowerPoints and Overview



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Greetings, All!

Thank you very much to those of you who attended the HPSG meeting yesterday. If you weren't able to make it, you were missed!!
I'm attaching the information that was presented to the group to this email, as promised.

If you have comments or questions, please do not hesitate to contact me.

We'll see you at the next HPSG meeting on March 21st at the Kent Offices (Room 309) from 10a-3pm.

Have a safe and fantastic holiday weekend!

My best,
Vanessa

Vanessa Leja, MPA
Gender Pronouns: she/her
HIV Community Planning Coordinator
Office of Infectious Disease
Disease Control and Health Statistics (DCHS)
Washington State Department of Health
vanessa.leja@doh.wa.gov
P: 360-236-3451 C: 360-710-5037 | www.doh.wa.gov
Gender Pronouns: she/her
<<https://twitter.com/wadepthealth?lang=en>>
<<https://www.facebook.com/WADeptHealth/>>
<<https://www.instagram.com/wadepthealth/>>
<<https://www.youtube.com/channel/UCTSCpezTD0TjiiAOuJY7f5w/doh>>
<<https://medium.com/@WADeptHealth>>

HIV in PWID Special Emphasis Workgroup

December 2018 – January 2019

DRAFT Recommendations to HPSG

Key points:

- The increase in new HIV infections among persons who inject drugs (PWID) in Seattle requires an immediate response to stem new infections and link people to care.
- This population includes, but is not limited to, people who use drugs, people living houseless, people engaging in sex work, and individuals indicating heterosexual sex.
- There are insufficient health care resources currently in place in the area in North Seattle most affected by the increase in HIV.
- There are potentially other resources besides HIV funding to improve health care and behavioral health services for this population some primary needs in addition to HIV Prevention and Care Services include access to medication assisted treatment (MAT) for opioid use, STD testing and treatment, hepatitis C testing and treatment, and mental health services. The extent to which these resources can be marshaled to address the problem of HIV among PWID is not yet certain.

Short Term

- **PHSKC** is reallocating staff and funding to provide outreach testing and testing in the King County Jail
- **PHSKC** is working with emergency departments to increase HIV testing and with local healthcare organizations to identify opportunities to expand care for PWID who are living homeless
- **PHSKC** to look for alternative monies until July
- **PHSKC** to provide a budget for proposed activities to address the situation in north Seattle; such as jail testing in KC
- **SHE Clinic/UW** to continue to bill Medicaid for women to get them on meds to stretch funding already allocated to them
- **Aurora Commons** requested additional (1.0) FTE to increase work for female-identified participants and expand to work with male-identified participants
- **OID:** Considering request and problem solving contracting issue
- **OID:** Determine feasibility and necessity to quickly scale up HIV testing among PWID outside of King County
- **OID:** Reach out to HCA to determine if additional support for health care services can be provided
- **OID:** Send out a statewide alert to medical providers and social service organizations that serve PWID

Medium Term

- **OID:** Will update End AIDS Washington recommendations to reflect more up-to-date data/information about HIV among PWID in Washington
- **OID:** Assessment of how to improve access to HIV and HCV testing and HAV/HBV vaccination at syringe service programs throughout the state
- **OID:** Identify opportunities for financing syringe service programs to provide whole person health care to, and to manage the infectious disease consequences of, injection drug use.
- **OID:** Convene Epi group to evaluate scale of problem and needs – Landscape analysis to assess the size of the pop at risk, and the service needs. Shoot for a compressed timeline – convene in Jan or early Feb and have an initial report and plan for additional data collection and work by April 1.

HIV in PWID Special Emphasis Workgroup

December 2018 – January 2019

DRAFT Recommendations to HPSG

Long Term

- **PHSKC** to make recommendations to OID/DOH regarding funding including: payers, systems, agencies for a more comprehensive approach to clinical services for PWID in north Seattle
- **OID/PHSKC** look for resources to start a brick and mortar clinic in north Seattle
- **ALL:** Work on efforts to support expansion of the SHE Clinic to respond to the demand for health care in Aurora/northwest Seattle area

SEW Participants included:

Lisa Etter-Carlson and Sherice, Aurora Commons;

Shireesha Dhanireddy, Harborview Medical Center/SHE Clinic;

Matt Golden, Karen Hartfield, Joe Tinsley, Public Health – Seattle and King County;

Nicole Price – BABES;

Jason Sterne and Chelsie Porter, HEP Education Project;

Susan Kingston, University of Washington;

Beth Crutsinger-Perry, Tom Jaenicke, Emalie Hurlaux, Sarah Deutsch, Jen Reuer, Michael Barnes, Vanessa Leja, Washington State Department of Health, Office of Infectious Disease











From: Mary Goelz

Sent: 1/16/2019 1:45:47 PM

To: Turner, Susan (DOHi), Flake, Marie D (DOH), Black, Ryan (DOH), Bodden, Jaime (DOHi), Burkland, Anne (DOHi), Calder, Allegra (DOHi), Courogen, Maria (DOH), Davis, Michelle (DOH), Debolt, Meghan (DOHi), Delahunt, Regina (DOHi), Dzedzy, Ed (DOHi), Halvorson, Clark R (DOH), Joyner, Pama (DOH), Ketchel, Jeff (DOHi), Kirkpatrick, Vicki (DOHi), Lindquist, Scott W (DOH), Melnick, Alan (DOHi), Miller, Angi (DOH), Rohr Tran, Holly (DOHi), Schanz, Matt (DOHi), Schuler, Christopher (DOHi), Tammy Axlund, Wilson, Lyndia (DOHi), Windom, David (DOHi), Wolfe, Roxanne (DOHi), Worsham, Dennis (DOHi), York, Danette (DOHi)

Cc:

Subject: RE: FPHS TWG Meeting 1/18/19 - proposed language for lab

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 *attachments\E0BE7016D3C94F5D_image010.png*
 *attachments\CEB9B351758A4CC4_image003.png*

I also like this description, Mary

Mary P. Goelz | Director
Pacific County Public Health and Human Services
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P: 360.875.9343 | F: 360.875.9323
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After hours: 360.875.9397

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From: Susan Turner <Susan.Turner@kitsappublichealth.org>

Sent: Wednesday, January 16, 2019 1:00 PM

To: Flake, Marie D (DOH) <marie.flake@doh.wa.gov>; Black, Ryan (DOH) <Ryan.Black@DOH.WA.GOV>; Bodden, Jaime (DOHi) <Jbodden@wsac.org>; Burkland, Anne (DOHi) <Anne.Burkland@kingcounty.gov>; Calder, Allegra (DOHi) <allegra@berkconsulting.com>; Courogen, Maria (DOH) <Maria.Courogen@DOH.WA.GOV>; Davis, Michelle (DOH) <Michelle.Davis@sboh.wa.gov>; Debolt, Meghan (DOHi) <mdebolt@co.walla-walla.wa.us>; Delahunt, Regina (DOHi) <rdelahun@whatcomcounty.us>; Dzedzy, Ed (DOHi) <edzedzy@co.lincoln.wa.us>; Mary Goelz <mgoelz@co.pacific.wa.us>; Halvorson, Clark R (DOH) <Clark.Halvorson@DOH.WA.GOV>; Joyner, Pama (DOH) <Pama.Joyner@DOH.WA.GOV>; Ketchel, Jeff (DOHi) <jketchel@snohd.org>; vkirkpatrick@co.jefferson.wa.us; Lindquist, Scott W (DOH) <scott.lindquist@doh.wa.gov>; Melnick, Alan (DOHi) <alan.melnick@clark.wa.gov>; Miller, Angi (DOH) <Angi.Miller@DOH.WA.GOV>; Rohr Tran, Holly (DOHi) <Holly.RohrTran@kingcounty.gov>; Schanz, Matt (DOHi) <mschanz@netchd.org>; Schuler, Christopher (DOHi) <cschuler@tpchd.org>; Tammy Axlund <taxlund@co.whatcom.wa.us>; Wilson, Lyndia (DOHi) <Lwilson@srhd.org>; Windom, David (DOHi) <DWindom@co.mason.wa.us>; Wolfe, Roxanne (DOHi) <Roxanne.wolfe@clark.wa.gov>; Worsham, Dennis (DOHi) <Dennis.worsham@kingcounty.gov>; York, Danette (DOHi) <danette.york@lewiscountywa.gov>
Subject: RE: FPHS TWG Meeting 1/18/19 - proposed language for lab

This is excellent, and for my part, I agree. Susan

Susan Turner MD, MPH, MS | Health Officer
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<<https://www.facebook.com/KitsapPublicHealthDistrict>>

From: Flake, Marie D (DOH) <marie.flake@doh.wa.gov>
Sent: Tuesday, January 15, 2019 4:15 PM
To: Black, Ryan (DOH) <Ryan.Black@DOH.WA.GOV>; Bodden, Jaime (DOHi) <Jbodden@wsac.org>; Burkland, Anne (DOHi) <Anne.Burkland@kingcounty.gov>; Calder, Allegra (DOHi) <allegra@berkconsulting.com>; Courogen, Maria (DOH) <Maria.Courogen@DOH.WA.GOV>; Davis, Michelle (DOH) <Michelle.Davis@sboh.wa.gov>; Debolt, Meghan (DOHi) <mdebolt@co.walla-walla.wa.us>; Delahunt, Regina (DOHi) <rdelahun@whatcomcounty.us>; Dzedzy, Ed (DOHi) <edzedzy@co.lincoln.wa.us>; Flake, Marie D (DOH) <marie.flake@doh.wa.gov>; Goelz, Mary (DOHi) <mgoelz@co.pacific.wa.us>; Halvorson, Clark R (DOH) <Clark.Halvorson@DOH.WA.GOV>; Joyner, Pama (DOH) <Pama.Joyner@DOH.WA.GOV>; Ketchel, Jeff (DOHi) <jketchel@snohd.org>; vkirkpatrick@co.jefferson.wa.us; Lindquist, Scott W (DOH) <scott.lindquist@doh.wa.gov>; Melnick, Alan (DOHi) <alan.melnick@clark.wa.gov>; Miller, Angi (DOH) <Angi.Miller@DOH.WA.GOV>; Rohr Tran, Holly (DOHi) <Holly.RohrTran@kingcounty.gov>; Schanz, Matt (DOHi) <mschanz@netchd.org>; Schuler, Christopher (DOHi) <cschuler@tpchd.org>; Tammy Axlund <taxlund@co.whatcom.wa.us>; Susan Turner <susan.turner@kitsappublichealth.org>;

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<danette.york@lewiscountywa.gov>
Subject: FPHS TWG Meeting 1/18/19 - proposed language for lab

TWG,
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Just a thought

Ed Dzedzy
Lincoln County

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functional definitions – for this moment in time. Connection info is below and should be on your calendar.

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Connection

* Webinar: <https://global.gotomeeting.com/join/990414661>

* Audio by phone: (872) 240-3212 / Access Code: 990-414-661

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* Page 29, G (CD) 1 (Data) – b (Immunization Information System) – Centralized Activity; c, d, f – adding effort for data input, quality, educating providers.

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* Page 50, K (Access) 3 (Licensing) – Centralized Activity

* Page 52, L (VR) 1 (Data system) – Centralized Activity

Talk with you next week.

Marie

Marie Flake

Special Projects

Systems Transformation I Office of the Secretary

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<<https://medium.com/@WADeptHealth>>

From: Czapla, Monica
Sent: 1/18/2019 12:57:38 PM
To: Matheson, Jasmine S (DOH)
Subject: RE: CD Epi Support for GCD - Clark County



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attachments\F648AFA742504853_image010.png



attachments\990A24DFD94742E1_image009.jpg

Halstenson, Gentle <Gentle.Halstenson@clark.wa.gov>

<<https://www.clark.wa.gov/>>

Monica Czapla, MPH
Program Manager - Infectious Diseases
PUBLIC HEALTH

564.397.8002 (note: our office area code has changed)
360.836.9086 cell

<<https://www.facebook.com/pages/Clark-County-WA/1601944973399185>>
<<https://twitter.com/ClarkCoWA>> <<https://www.youtube.com/user/ClarkCoWa/>>

From: Matheson, Jasmine S (DOH) [mailto:Jasmine.Matheson@DOH.WA.GOV]
Sent: Thursday, January 17, 2019 6:02 PM
To: Czapla, Monica
Cc: Boysun, Mike (DOH); Harry, Cynthia S (DOH); DOH-OSC (DOH)
Subject: CD Epi Support for GCD - Clark County

Hi Monica

Our office is able to assist in supporting GCD investigations for Clark County.

Points of contact:

- * VPD (non-measles outbreak): Amy Poel
- * Enterics: Beth Melius
- * Zoonotic Diseases: Hanna Oltean
- * Influenza/Legionella: Vivian Hawkins
- * Hepatitis B (acute): Marcia Goldoft
- * HAI: Sara Podczervinski

We are currently able to support creating cases in WDRS, investigation and public health actions and data entry. For each condition area it will be important to transition existing Clark County cases and establish any condition-specific protocols. Currently there are 19 open investigations in WDRS for Clark County. For new cases, we'll need to set up designated processes and address condition specific questions. For example, investigation of immediately notifiable conditions and public health actions – does Clark want to be aware of these investigations at all or be directly involved (e.g., prophylaxis)?

Does Clark County have a COOP plan that might be able to guide prioritization of cases?

If you could please connect Mike Boysun and Cynthia Harry to the best person from your staff to facilitate transition of GCD work, the subject matter leads can provide suggestions and jointly plan to ensure effective follow-up.

Thanks and see you tomorrow.
Jasmine

Jasmine Matheson, MPH
Program Manager / Refugee Health Coordinator
Disease Control and Health Statistics
Washington State Department of Health
jasmine.matheson@doh.wa.gov
206-418-5603 | www.doh.wa.gov
<<https://www.doh.wa.gov/Newsroom/SocialMedia>>

This e-mail and related attachments and any response may be subject to public disclosure under state law.

From: Susan Turner

Sent: 1/16/2019 1:00:10 PM

To: Flake, Marie D (DOH), Black, Ryan (DOH), Bodden, Jaime (DOHi), Burkland, Anne (DOHi), Calder, Allegra (DOHi), Courogen, Maria (DOH), Davis, Michelle (DOH), Debolt, Meghan (DOHi), Delahunt, Regina (DOHi), Dzedzy, Ed (DOHi), Goelz, Mary (DOHi), Halvorson, Clark R (DOH), Joyner, Pama (DOH), Ketchel, Jeff (DOHi), Kirkpatrick, Vicki (DOHi), Lindquist, Scott W (DOH), Melnick, Alan (DOHi), Miller, Angi (DOH), Rohr Tran, Holly (DOHi), Schanz, Matt (DOHi), Schuler, Christopher (DOHi), Tammy Axlund, Wilson, Lyndia (DOHi), Windom, David (DOHi), Wolfe, Roxanne (DOHi), Worsham, Dennis (DOHi), York, Danette (DOHi)

Cc:

Subject: RE: FPHS TWG Meeting 1/18/19 - proposed language for lab



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attachments\E81DE06D3C714481_image024.png

This is excellent, and for my part, I agree. Susan

Susan Turner MD, MPH, MS | Health Officer

Kitsap Public Health District

345 6th St., Suite300 | Bremerton, WA 98337

(360)728-2250 Office | (360)728-2235 Main

susan.turner@kitsappublichealth.org | [kitsappublichealth.org](http://www.kitsappublichealth.org)

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From: Shafar, Lindsey
Sent: 1/18/2019 12:48:54 PM
To: Cleveland, Annette, Winters, Vickie, Stonier, Monica, 'sarah.kohout@leg.wa.gov', Wylie, Sharon, 'Walsh, Megan', Wilson, Lynda, Hardtke, Amber (GMB), Harris, Paul, 'toni.camp@leg.wa.gov', Kraft, Vicki, 'tori.benson@leg.wa.gov', Rivers, Ann, Nelson, Michael, Vick, Brandon, Gilmour, Peter (GMB), Hoff, Larry, Quiring, Eileen, Blom, John, Lentz, Temple, Olson, Julie (Councilor), Henessee, Shawn
Subject: Clark County measles outbreak - visit with Secretary of Health TOMORROW



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Good afternoon,

As you know, the Clark County Public Health Department is currently in the midst of responding to a measles outbreak in Clark County. Of course, responding to disease outbreaks is a primary part of foundational public health services.

In your role as a legislator, you play a key role in the current discussions regarding foundational public health. Secretary of Health Dr. John Wiesman will be in Clark County tomorrow, and he and Clark County Public Health Officer Dr. Alan Melnick would like to invite you and our Board of Health to an information session on the current status of the measles outbreak, the public health work that is being done, and what the next steps will be. This meeting will be:

Tomorrow, Saturday, January 26th

2:30 PM

Center for Community Health, 1601 East Fourth Plain Blvd in Vancouver. It is Building 17, near the VA.

If you are unable to attend in person, please let Lydia Gherman know (Lydia.gherman@clark.wa.gov) and she will get you conference call information.

As always, if you have questions, please let me know.

Thanks!

Lindsey

Lindsey Shafar
Senior Policy Analyst – Clark County Council
COUNTY MANAGER'S OFFICE
564.397.4157

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This e-mail and related attachments and any response may be subject to public

disclosure under state law.

In Preparation for *Emerging Infectious Diseases*: Research Article

Word count maximum: 3500

Epidemiology of Tick-borne Pathogens in Washington State, 2010-2016

Elizabeth A. Dykstra^{1*}, Hanna N. Oltean^{1*}, David Kangiser¹, Nicola Marsden-Haug¹ Stephen M. Rich², Guang Xu², Rebecca J. Eisen³, Christine B. Graham³, Muhammad G. Morshed⁴, and Min-Kuang Lee⁴

*These first authors contributed equally to this article

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³Division of Vector-Borne Diseases, Centers for Disease Control and Prevention, Ft. Collins, CO (dyn2@cdc.gov, hyb4@cdc.gov)

⁴British Columbia Public Health Microbiology and Reference Laboratory, Vancouver, British Columbia, Canada (muhammad.morshed@bccdc.ca, min-kuang.lee@bccdc.ca)

Corresponding Author: E. A. Dykstra, elizabeth.dykstra@doh.wa.gov

Keywords: Tick-borne disease, *Ixodes*, *Dermacentor*, Washington,

Abstract: (limit 150, currently 149)

Tick-borne diseases are rare in Washington State (WA), and the epidemiology of these pathogens is poorly understood. We incorporated data from surveillance of ticks and humans to better describe the epidemiology. From October 2010 through December 2016, field drags collected 977 unfed ticks including *Ixodes pacificus*, *I. angustus*, *I. spinipalpis*, *I. auritulus*, *Dermacentor andersoni*, and *D. variabilis*. The prevalence of *Borrelia burgdorferi* sensu lato, *B. burgdorferi* sensu stricto, *B. miyamotoi*, and *Anaplasma phagocytophilum* in *I. pacificus* ticks was 7.4%, 4.2%, 4.4%, and 1.9%, respectively. No *Rickettsia rickettsii* were detected in *Dermacentor andersoni* or *D. variabilis*. During this time period, 226 tick-borne disease cases were reported in Washington residents; 79 (35%) of which were autochthonous. Conditions with autochthonous cases included Lyme disease, Rocky Mountain spotted fever, tick-borne relapsing fever, and tularemia. Human case histories and detection of pathogens in field-collected ticks indicate that several tick-borne pathogens are endemic to WA.

Introduction: (limit 3,500, currently 3,709)

Tick-borne diseases, caused by a variety of pathogens including bacteria, rickettsia, viruses, and protozoa, are the most common cause of vector-borne disease in humans in the United States (1). Tick-borne disease epidemiology is complex, the result of many component causes such as spatiotemporal variation in infected vectors, human behavior including time spent in tick-infested areas, abundance of hosts, capacity of tick hosts to serve as reservoirs, and climate variation (1,2). In Washington State (WA), the burden of tick-borne disease is much lower than in highly endemic areas such as the Northeast and Midwest United States; however, much of the epidemiology of these diseases in WA remains to be described.

Vectors

Keirans and Clifford reported eleven *Ixodes* species from WA, three of which are considered known or potential human disease vectors or play a role in pathogen maintenance (3). These include *Ixodes pacificus*, *I. angustus*, and *I. spinipalpis*. The western blacklegged tick, *I. pacificus*, is a recognized vector for *Borrelia burgdorferi* sensu stricto (s.s.), a causative agent of Lyme disease, as well as *B. miyamotoi* and *Anaplasma phagocytophilum* (4). *Ixodes angustus* is capable of experimental transmission of *B. burgdorferi* s.s. to humans and may play a role in the enzootic cycle of Lyme disease spirochetes (5, 6). Additionally, *I. spinipalpis* has been found naturally infected with *B. burgdorferi*, *B. bissettiae*, and *B. californiensis*, and is thought to play a role in the natural maintenance of these pathogens (7). Specimens of *I. spinipalpis* predominately found attached to people and submitted to the University of Massachusetts, Amherst, were infected with *B. lanei*, *B. burgdorferi* sensu lato (s.l.), and *A. phagocytophilum* (8).

Dermacentor andersoni and *D. variabilis*, both competent vectors of *Rickettsia rickettsii*, the causative agent of Rocky Mountain spotted fever (RMSF), and *Francisella tularensis*, which causes tularemia, are found in the state (4,9). The brown dog tick, *Rhipicephalus sanguineus*, a known vector of RMSF as well as several canine tick-borne diseases, is reported to occur in WA (10, 11). *Borrelia hermsii*, the causative agent of tick-borne relapsing fever (TBRF), is vectored by *Ornithodoros hermsi*, a soft tick (family Argasidae) typically found in rodent nests, both in cabins as well as in the natural environment (12, 13).

Reservoir Hosts

Deer mice (*Peromyscus maniculatus*), a primary reservoir for *B. burgdorferi* s.s., are found throughout much of the state and have been found infected with *B. burgdorferi* s.l. in western WA (14). The western gray squirrel (*Sciurus griseus*), a competent reservoir of *B. burgdorferi* s.s., is found in three distinct locations in the state, each population well isolated from the others (15, 16). A number of *Tamias* spp. chipmunks are also competent reservoirs of *B. burgdorferi* s.l. and *A. phagocytophilum*, including the redwood chipmunk (*T. ochrogenys*) in northern California (CA) (17). Three known reptile hosts of *I. pacificus* are found in WA: the northern alligator lizard (*Elgaria coerulea*), the southern alligator lizard (*E. multicaudata*), and the western fence lizard (*Sceloporus occidentalis*) (18, Arnason CS. Biology of the western black-legged tick, *Ixodes pacificus*, (Cooley and Kohls, 1943): A potential vector of Lyme disease in south coastal British Columbia. M.S. Thesis, Simon Fraser University. 1992;64). Both *S. occidentalis* and *E. multicaudata* are not only incompetent reservoirs, but their blood also contains borreliacidal properties that clear *B. burgdorferi* from ticks feeding on them (19, 20).

Pathogen identification reports (human, animal, tick)

Cases of Lyme disease and *B. burgdorferi*-infected *I. pacificus* ticks have been documented on the West Coast, including in CA and British Columbia (BC), Canada (21, 22). Cases of Lyme disease in WA, with and without travel history, have been reported (23). In addition, a study using a convenience sample of canine sera documented canine seroprevalence of 3.8 cases/1,000 dogs tested by ELISA using the C6 peptide (24).

Anaplasma phagocytophilum, which causes anaplasmosis, has been reported in small mammals (25, 26) and in *I. pacificus* ticks in California (27), as well as in dogs in BC, WA, Oregon (OR), and CA (24, 28, 29).

Rare cases of autochthonous babesiosis have been reported in WA, three caused by *Babesia duncani* and one caused by *B. divergens*-like organism (30, 31, 32). Evidence of *D. albipictus* as the vector for *Babesia duncani*, the species described in most cases in WA and CA, has only recently emerged (33).

Historically, locally acquired cases of RMSF were reported in WA each year until the 1940's (34). Although published evidence of *R. rickettsii* in ticks in WA is not available, *R. rickettsii* has been detected in *Dermacentor* species ticks collected in eastern WA (K. Magori, pers. comm.).

The most commonly reported autochthonous tick-borne disease in WA is TBRF, with up to 12 cases reported each year (34). In addition, the first documented evidence of canine infection with *B. hermsii* was reported in a dog with travel to Chelan County, WA (35). *Borrelia hermsii*-positive *Ornithodoros hermsi* ticks have been documented in WA (36).

Tularemia is prevalent throughout the Northern Hemisphere and has been recovered from many animal species (37). Recent *F. tularensis* antibody positive results were reported from wildlife collections in Idaho (38). Up to ten cases of tularemia are reported each year in WA.

Human cases of Lyme disease, anaplasmosis, ehrlichiosis, babesiosis, spotted fever rickettsioses (including RMSF), TBRF, and tularemia are notifiable to Local Health Jurisdictions (LHJs) in WA. However, clinical under-recognition and under-reporting of disease are suspected. To gain a better understanding of tick-borne disease epidemiology in WA, we analyzed tick surveillance data and locally-acquired tick-borne disease cases. The objectives of this summary review are to 1) describe the tick-borne disease vectors identified in WA, 2)

describe pathogen detections in ticks in WA, and 3) describe tick-borne disease epidemiology among autochthonous human cases in WA.

Materials and Methods

Tick Surveillance

The WA State Department of Health (DOH) began an active tick surveillance program in fall of 2010. Ticks were collected via drags and host inspections. Surveillance efforts also included partnering with veterinarians, wildlife biologists, healthcare professionals, and the general public to obtain ticks from a variety of vertebrate hosts. DOH staff conducted weekly tick drags from March through October each year, except 2010, when ticks were only collected in the fall, at sites identified as having suitable tick habitat and access by the public for recreational use. Drags were also performed in areas deemed most likely exposure locations for locally-acquired Lyme disease cases reported during 2010-2016. Tick drags were conducted using one square meter of flannel that was dragged on the ground along either a 30 meter transect or for 30 minutes in a plot created in a specific vegetation type. Drags were inspected for ticks every three to six meters.

Upon collection, ticks were placed into labelled vials of 95% ethyl alcohol and stored at 4°C. Ticks were identified to species using standard taxonomic keys (3, 39, 40). *Ixodes* ticks were tested for *A. phagocytophilum*, *B. burgdorferi* s.s. and s.l., *B. miyamotoi*, *B. mayonii*, *Babesia* species, *Ba. microti*, *Ehrlichia muris*-like agent, Powassan virus, Heartland virus, Colorado tick fever virus, and Bourbon virus. *Dermacentor* ticks were tested for *F. tularensis*, *R. rickettsii*, *R. montanensis*, *R. peacocki*, and *R. rhipicephali*, along with Powassan, Heartland, Colorado tick fever, and Bourbon viruses. Specimens selected for pathogen testing were

submitted to either the Laboratory of Medical Zoology, University of Massachusetts – Amherst, the Centre for Disease Control – British Columbia (BC-CDC), Vancouver, BC, or the Centers for Disease Control and Prevention (CDC), Fort Collins, CO.

Pathogen testing varied by lab and over time; groups of ticks were tested by different labs for different pathogens, which resulted in differences between species and pathogens tested. Detections of *Borrelia burgdorferi* s.l. in ticks tested before 2015 were not sub-specified.

DNA extraction and molecular identification

Testing of *Ixodes* and *Dermacentor* ticks at the Laboratory of Medical Zoology, University of Massachusetts followed the protocols described by Xu et al. (8). Testing of *Ixodes* ticks at the CDC followed the protocols described by Graham et al. (41). Testing of *Ixodes* ticks at the BC – CDC followed the protocols described by Morshed et al. (42).

Host distribution maps were based on those created by the Nature Mapping Foundation (43).

Human Case Identification

Human cases of tick-borne disease were identified through passive reporting to local health jurisdictions (LHJs) from healthcare providers in WA and laboratories performing testing for WA residents. All reported cases of anaplasmosis, ehrlichiosis, Lyme disease, babesiosis, TBRF, RMSF, and tularemia during 2010-2016 were reviewed and reclassified to the most recent Council for State and Territorial Epidemiologists (CSTE) case definitions as of 2017. Confirmed and probable cases were included for each condition. Reclassifications were required for Lyme disease (2017 definition), babesiosis (2011 definition), and tularemia (2017 definition). Reported cases were interviewed by LHJs in the year of report to determine clinical course,

travel history, and most likely exposure location. Cases were classified as locally-acquired, out-of-state acquired, or unknown exposure location based on a standardized definition. For descriptive analysis, frequency distribution of demographic variables was evaluated for each condition with locally-acquired cases reported.

Results

A total of 3,225 ticks representing seven tick species were collected from October 2010 through December 2016 and submitted for pathogen testing. Of these, 977 were unfed, field-collected ticks from 52 sites in 19 counties, from known collection points. These included *I. pacificus* (n=449), *I. angustus* (n=99), *I. spinipalpis* (n=225), *I. auritulus* (n=5), *D. variabilis* (n=46), *D. andersoni* (n=151), and two un-specified *Ixodes* larvae.

Ticks were primarily active during the spring, with 62% of all ticks collected during the months of March through May. Public tick submissions were substantially greater in the spring, likely reflecting increased host seeking behavior and human-tick interactions. Almost all *Ixodes* ticks submitted from the public, especially *I. pacificus*, were adult ticks. This was mirrored in field collections, where adults were the primary stage collected, although most *I. spinipalpis* collected were nymphs.

Borrelia burgdorferi s.s. was detected in 4.2% (15/354) of *I. pacificus* (**Table 1**). However, detections were made from only three counties; Clallam, 12/121 (9.9%), Klickitat, 2/117 (1.7%), and Yakima, 1/3 (33.3%) (**Figure 1**). *Borrelia burgdorferi* s.s. was also detected in 1/66 (1.5%) *I. spinipalpis* (**Table 1**). The first detections of *B. miyamotoi* in WA were found in 10/227 (4.4%) *I. pacificus*. *Borrelia bissettiae* and *B. lanei* were found in *I. spinipalpis*. Both *I. pacificus* (1.9%) and *I. spinipalpis* (0.5%) were found infected with *A. phagocytophilum*.

Borrelia burgdorferi s.l. was detected in *I. pacificus* (7.4%), *I. spinipalpis* (2.7%), and *I. angustus* (1.0%), the only pathogen detected in this species. Six *I. pacificus* ticks were co-infected with two pathogens, including four with *B. burgdorferi* s.s. and *B. miyamotoi*; one with *B. burgdorferi* s.s. and *A. phagocytophilum*; and one with *Borrelia* spp. and *A. phagocytophilum*.

Both *R. peacocki* and *R. rhipicephali* were detected in *D. andersoni* (36%, 9.0%) and *D. variabilis* (4.8%, 2.4%) from multiple counties in eastern WA (**Table 2, Figure 2**). *Rickettsia rickettsii* and *F. tularensis* were not detected in any unfed *Dermacentor* ticks, but *F. tularensis* and several other pathogens were detected in ticks collected from vertebrate hosts (Supplemental Tables 1 and 2).

During 2010-2016, 226 tick-borne disease cases were reported in Washington residents. Of these, 79 (35%) were autochthonous cases; conditions with cases classified as in-state exposure reported included Lyme disease (18 cases), RMSF (2 cases), TBRF (31 cases), and tularemia (28 cases). Yearly case counts of locally-acquired conditions were very low, with fewer than 20 total cases reported each year (**Figure 3A**). TBRF was the most frequently reported autochthonous tick-borne disease; all cases reported exposure in eastern Washington, with the highest case counts reported in Okanogan and Spokane counties. Tularemia was the second most commonly reported condition, with case exposures across the state. Low numbers (2-6 cases) of locally-acquired Lyme disease were reported each year; likely exposure locations involved 13 WA counties in both eastern and western WA. Only two probable cases of RMSF were reported during this time period, both with likely exposure in north central WA. Tick-borne disease cases were reported throughout the year, with the highest case counts reported from April-October. TBRF cases peaked in September, tularemia cases peaked in July, and Lyme disease cases peaked in May (data not shown).

Lyme disease was the most commonly reported imported tick-borne disease and overall case counts of imported Lyme disease increased over the study period (**Figure 3B**). Low numbers of travel-associated anaplasmosis, babesiosis, RMSF, and TBRF were reported during this period. Two cases of blood transfusion-associated babesiosis were reported: one in 2014 and one in 2015. The blood donors in each case were WA residents with travel history to endemic states (Connecticut and Massachusetts). No human cases of *Borrelia miyamotoi* infection, imported or autochthonous, were reported in Washington residents during this period.

No significant differences in age or gender distribution were identified between locally-acquired tick-borne disease cases and imported cases or cases with unknown exposure history. Among autochthonous cases, 42% were female, and ages ranged from 1-91 years, with a median of 49 years. Imported cases were 37% female, and ages ranged from 3-87 with a median of 49 years.

Discussion

Although WA is considered a low-incidence state for tick-borne diseases, including Lyme disease, our results indicate that the tick populations here are infected with several disease-causing agents. Tick-borne diseases now known to be endemic in at least some areas of WA include Lyme disease, babesiosis, tularemia, tick-borne relapsing fever, Rocky Mountain spotted fever, anaplasmosis, and *Borrelia miyamotoi* infection. Both human healthcare providers and veterinarians should be aware of the possible risk of these diseases in their patients, and vigilant for consistent symptoms paired with exposure histories.

All *B. burgdorferi* s.l. detections in *I. pacificus* that were sequenced resulted in confirmation of *B. burgdorferi* s.s., suggesting that historical detections of *B. burgdorferi* may also have been pathogen (sensu stricto) detections. *Ixodes pacificus*, the west coast's primary

Lyme disease vector, was found with pathogenic strains of *B. burgdorferi* in three counties; in contrast, human cases of Lyme disease reported exposure in 13 counties.

The exceptionally high prevalence of 18.1% of *B. burgdorferi* s.l. and 9.9% of *B. burgdorferi* s.s. in *I. pacificus* ticks found in Clallam County, relative to other sample sites, suggest that at least one very competent reservoir host exists in the area. Interestingly, no human cases of Lyme disease reported exposure in Clallam County. This is possibly due to limited human-tick interaction in this area, although several popular outdoor sites and a National Park in the county call this theory into question. Further studies are needed to determine the most likely reservoir in this area and to better describe human-vector interactions. All dually-infected *I. pacificus* were also collected in Clallam County, indicating that there may be a competent reservoir for multiple pathogens.

In contrast, Klickitat County *I. pacificus* ticks had much lower prevalence of *B. burgdorferi* s.s., but three human cases of Lyme disease reported likely exposure in Klickitat County. *Ixodes pacificus* is known to feed on northern alligator, southern alligator, and western fence lizards. The hotter, drier habitat found in Klickitat County supports all three lizard species as well as others and may be the reason why, despite the abundant tick population, the pathogen prevalence is lower. Our Klickitat County study sites were located in popular recreation areas where people commonly encountered ticks; this might explain the higher number of exposures in the county in spite of the lower pathogen prevalence in the tick population.

There were eleven counties in which human Lyme disease cases reported exposure, but in which there were no positive detections of *B. burgdorferi* s.s.; for eight of these counties (Clark, Cowlitz, Grant, Island, Kitsap, Lewis, Okanogan, Pacific) no *I. pacificus* were field-collected; for two of these counties (Jefferson, Pierce), all field-collected *I. pacificus* tested negative or

were not tested; and for one county (Thurston), *B. burgdorferi* s.l. was detected, but not sub-speciated. Additional surveillance in these areas is needed to better describe the pathogen distribution.

Findings from this study provide evidence that *I. spinipalpis* plays a minor role in pathogen maintenance. The role of *I. spinipalpis* in transmission to humans is currently unknown. The almost total lack of pathogen detections found in unfed *I. angustus* suggest that this tick does not play a significant role in the maintenance or transmission of *B. burgdorferi* in WA.

Anaplasma phagocytophilum has been reported from dogs, but not people in WA. Strain variation of *A. phagocytophilum* with specific host tropism has been described; it is unknown at present whether the strain in WA differs in pathogenicity from strains in other endemic areas of the United States, or whether the lack of detection in humans is due to clinical under-recognition (44, 45). Both *I. pacificus* and *I. spinipalpis* were found infected with *A. phagocytophilum*, suggesting that both play a role in maintaining this pathogen in nature.

No detections of *R. rickettsii* or *F. tularensis* in unfed ticks in this study suggest that both of these pathogens are very rare. However, detections of *R. rickettsii* from *Dermacentor* species ticks in eastern WA, reported by personal communication, indicate that the pathogen is present in some tick populations. The presence of several non-pathogenic strains of *Rickettsia*, including *R. peacocki*, which is refractory to infection with and maintenance of *R. rickettsii* (46), suggest that *R. rickettsii* may only be present in focalized areas. Very low prevalence of *R. rickettsii* is supported by human case data, with only two cases reported during the study period. While tularemia is relatively common, the transmission routes for *F. tularensis* are varied and not limited to tick vectors.

Several limitations exist with our study. Field surveillance was conducted at a limited number of sites due to limited resources and efforts to focus on temporal tick activity in a given habitat over the course of a year. This resulted in inconsistent and largely convenience-based tick surveillance coverage across the state. Ideally, rodent trapping for blood samples would provide additional evidence of enzootic transmission, but was outside the scope of this study. There remains a paucity of understanding of what specific reservoirs drive the maintenance of these pathogens in nature. However, several known, competent reservoirs for *B. burgdorferi* s.s. exist in the counties where pathogens were detected in the tick population. Little is currently known about the epidemiology of *R. rickettsii* in WA; limited detections indicate the pathogen is very rare.

All human case reports described in this study arose from passive surveillance systems and locally-acquired cases required positive lab results. There is very likely under-diagnosis of tick-borne diseases, as patients may not seek healthcare and healthcare providers may be unaware of the possibility of exposure to tick-borne diseases. In addition, common laboratory tests may be negative early in the course of illness, and true cases may be missed. In contrast, many of the diagnostic tests used for tick-borne diseases have poor sensitivity and specificity (e.g. Lyme disease antibody testing), and may cross-react with other species (e.g. *Rickettsia* testing). The application of these tests in a low incidence setting decreases their positive predictive value, and some of the cases included in this analysis likely represent false-positive results. This is likely true for many of the probable Lyme disease cases, where symptoms did not meet the clinical criteria set in the CSTE case definition or symptom information was not available, as well as for the RMSF cases, both of which met the minimum cut-off value for IgG antibody. There is likely some misclassification of human case exposure location as there is no

way to determine exposure location with certainty. Finally, there may be unknown tick-borne disease pathogens present in WA for which diagnostic tests are not available. As awareness of tick-borne diseases increases in both the general population and among healthcare providers, we may see an increase in the number of cases due to increasing diagnosis and reporting.

Strengths of this study include tracking of tick collection methods and feeding status, which allowed stratification of tick data for analysis. This is important because submissions from ticks collected from hosts may not represent the true distribution in WA, but instead reflect the host's travel history. Additionally, field surveillance with drags were all conducted at known sites and, in most cases, at multiple times during the year. This provided a better picture of seasonal tick activity than single time points. Testing of individual ticks, as opposed to pooling, provided more exact information about pathogen prevalence in each site's tick population. With the exception of only a few ticks, all were identified to species prior to testing. All human cases were interviewed for case classification criteria and exposure history, including travel. This allowed us to distinguish travel-related cases from possible autochthonous cases, which is crucial to the understanding of tick-borne disease burden in WA. The analysis of human and tick data in tandem allowed for a more complete picture of the various pathogen distributions and prevalence in WA than analyzing either alone.

The true underlying morbidity of tick-borne diseases in Washington remains unknown. Several human and animal pathogens found in tick populations are endemic to WA, including *B. burgdorferi* s.s., *Babesia* spp., *F. tularensis*, *B. hermsii*, *R. rickettsii*, *A. phagocytophilum*, and *B. miyamotoi*; healthcare providers should be vigilant for consistent symptoms of disease and exposure histories. The rarity of tick-borne diseases in Washington creates a surveillance and diagnosis challenge, as it is difficult to maintain awareness and clinical suspicion for these

conditions in a low incidence setting. Ongoing surveillance is required to better understand the true burden of disease and to improve public health prevention messaging to healthcare providers and the public.

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Table 1. Pathogens detected in unfed, field-collected *Ixodes* species ticks, Washington State, 2010-2016.

	<i>I. angustus</i>	<i>I. pacificus</i>	<i>I. spinipalpis</i>
Pathogen	#Positive/#Tested	#Positive/#Tested	#Positive/#Tested
<i>Anaplasma phagocytophilum</i>	0/95	5/269 (1.9%)	1/219 (0.5%)
<i>Borrelia</i> species	1/98 (1.0%)	5/390 (1.3%)	2/220 (0.9%)
<i>Borrelia bissettiae</i>	0/41	0/205	1/64 (1.6%)
<i>Borrelia burgdorferi</i> s.l.	1/99 (1.0%)	32/432 (7.4%)	6/220 (2.7%)
<i>Borrelia burgdorferi</i> s.s.	0/45	15/354 (4.2%)	1/66 (1.5%)
<i>Borrelia lanei</i>	0/41	0/205	2/64 (3.1%)
<i>Borrelia miyamotoi</i>	0/42	10/227 (4.4%)	0/69

Table 2. Pathogens detected in unfed, field-collected *Dermacentor* species ticks, Washington, 2012-2016.*

	<i>D. andersoni</i>	<i>D. variabilis</i>
Pathogen	#Positive/#Tested	#Positive/#Tested
<i>Rickettsia</i> species	0/26	2/46 (4.3%)
<i>Rickettsia peacocki</i>	8/22 (36%)	2/42 (4.8%)
<i>Rickettsia rhipicephali</i>	2/22 (9.0%)	1/42 (2.4%)

**Dermacentor* ticks were not actively collected until 2012.

489 **Figure 1.** Maps of Washington showing counties of pathogen detections in unfed, field-collected
 490 *Ixodes pacificus* ticks from 2010-2016.

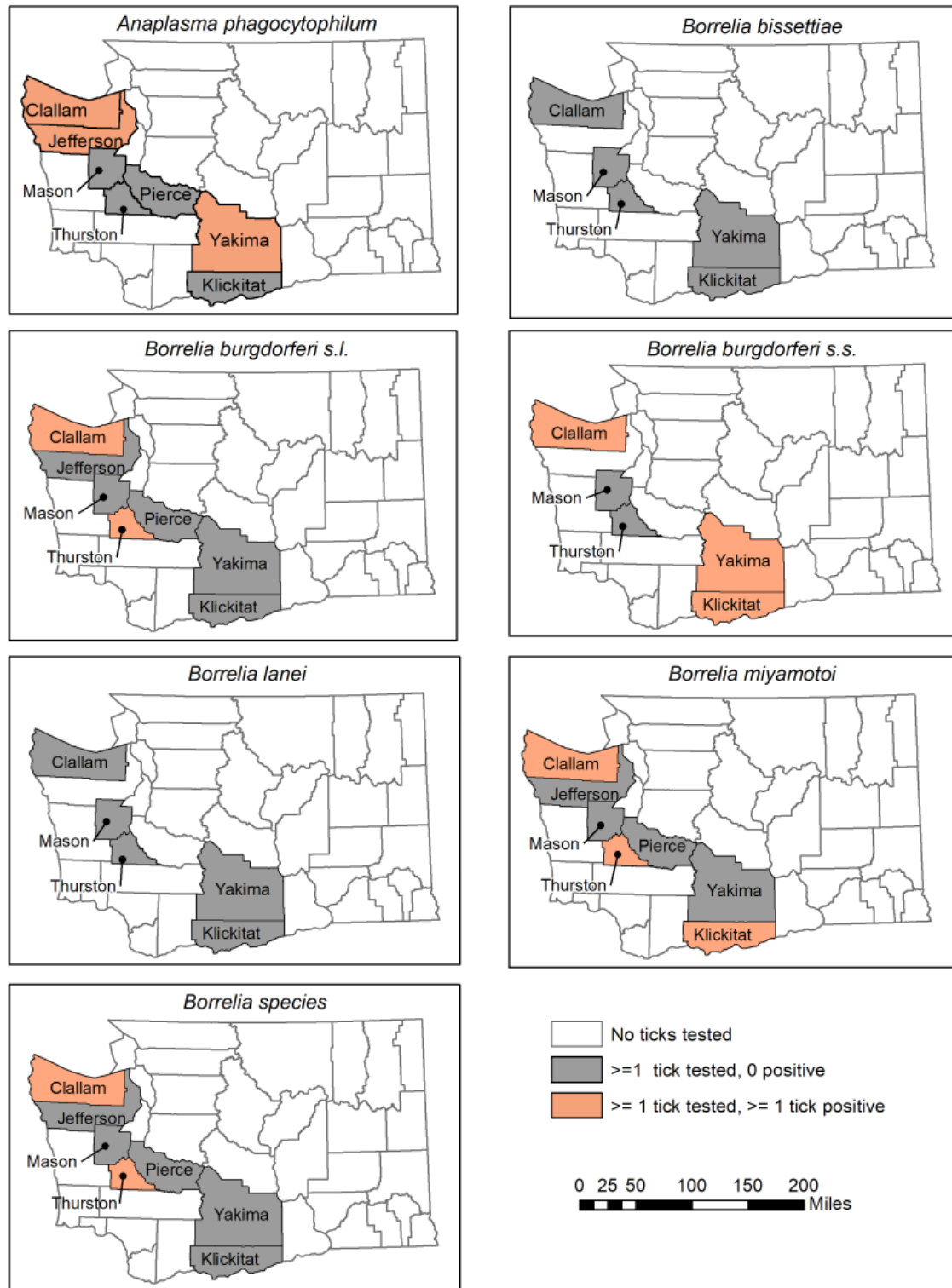


Figure 2. Maps of Washington showing counties of pathogen detections in unfed, field-collected *Dermacentor andersoni* and *D. variabilis* ticks from 2010-2016.

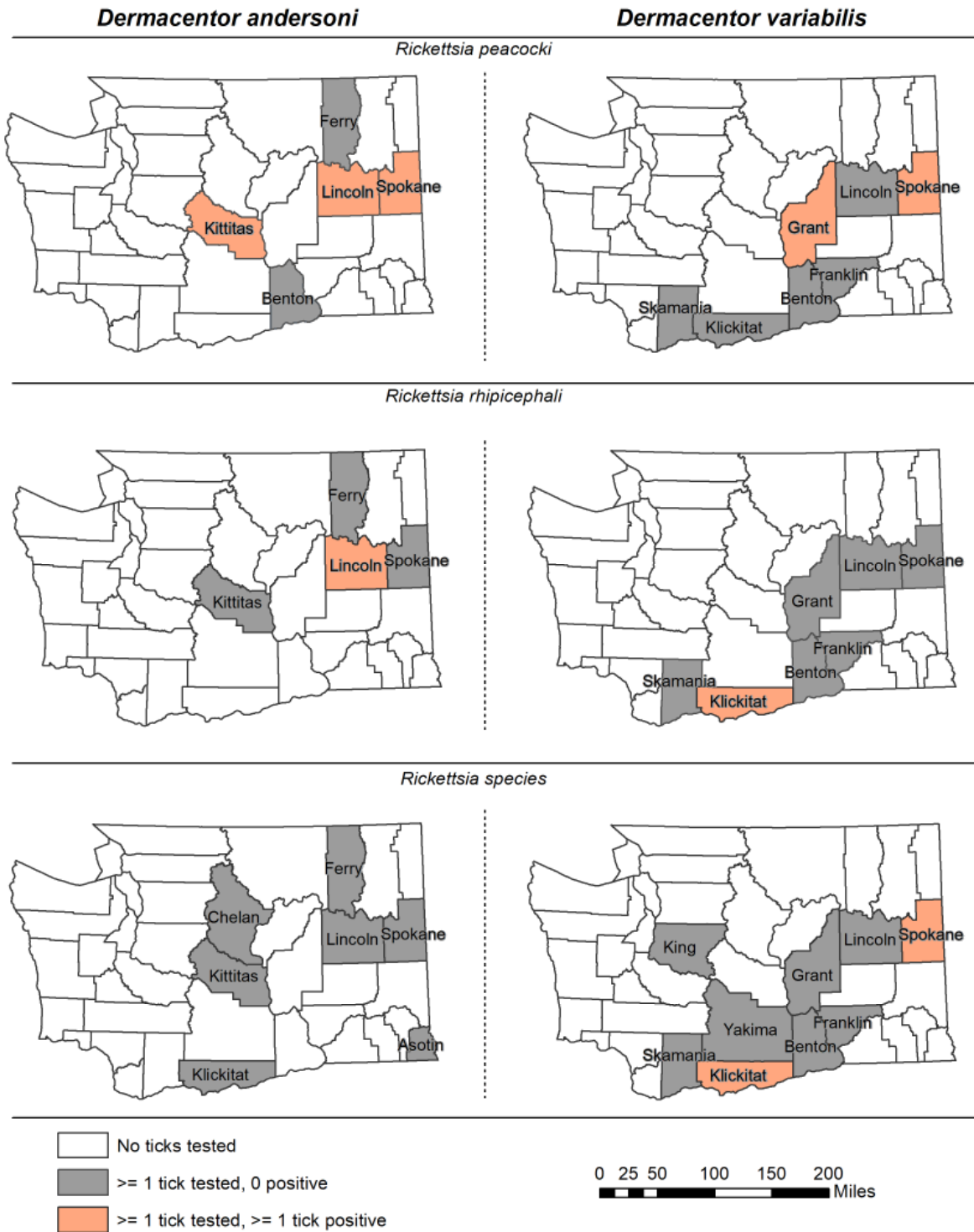


Figure 3A: Locally acquired cases of tick-borne diseases in Washington State, 2010-2016.

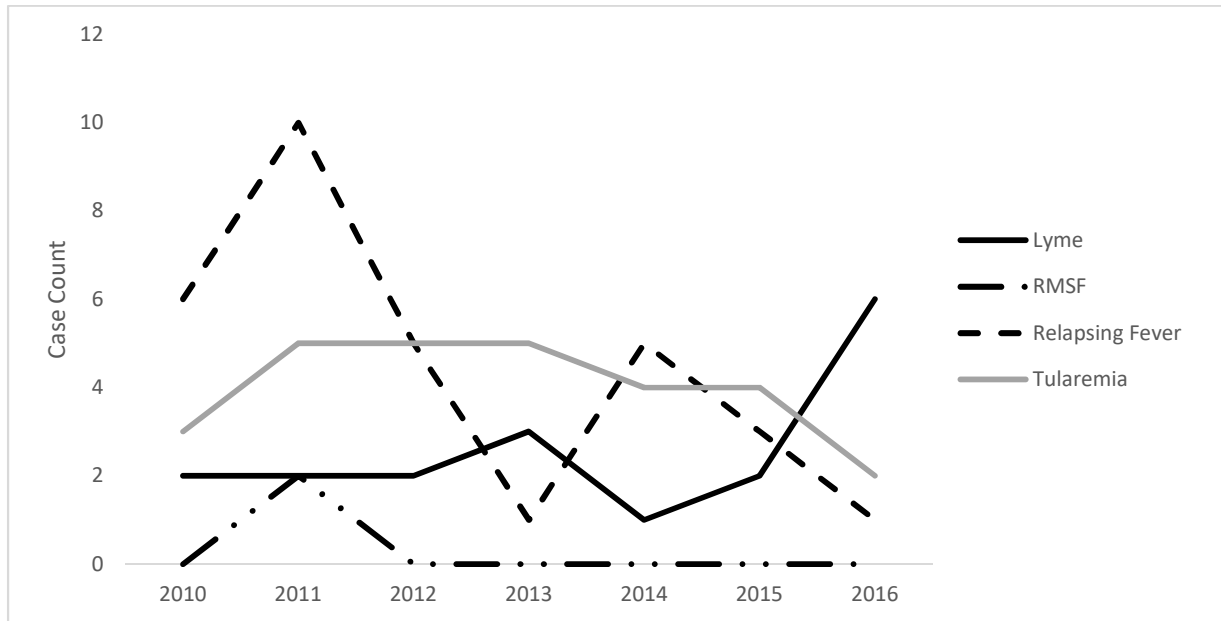
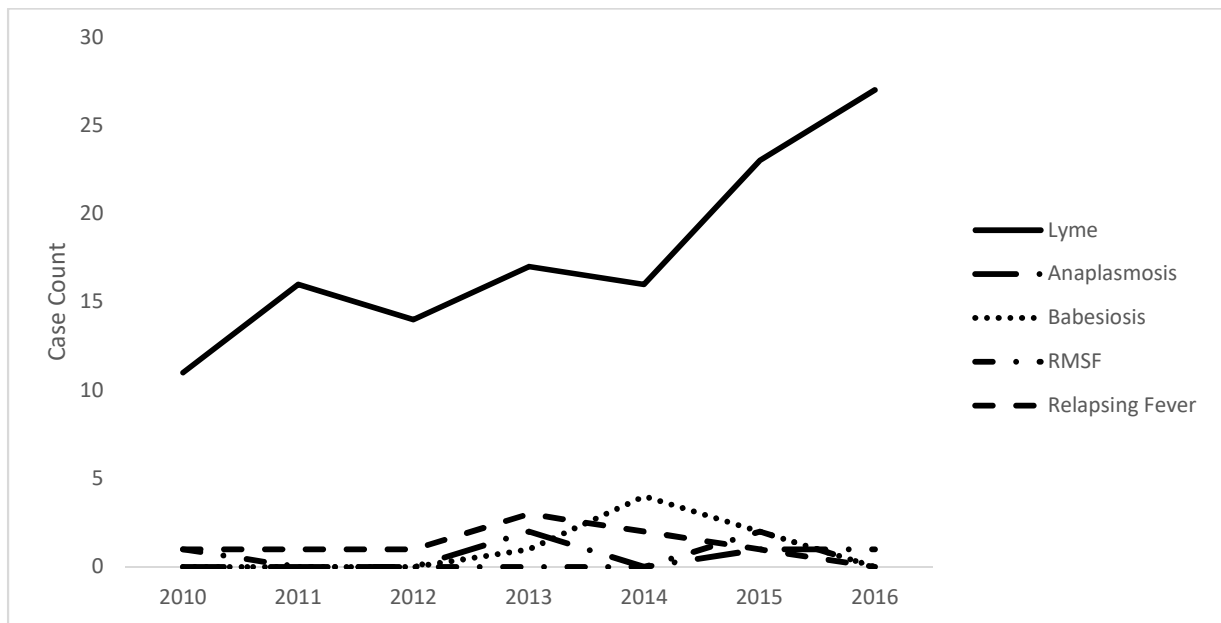


Figure 3B: Travel associated cases of tick-borne diseases in Washington State, 2010-2016.



Supplemental Data

Suppl. Table 1. Pathogens detected *Ixodes* species ticks collected from hosts or opportunistically at unknown locations in Washington State, 2010-2016.

	<i>I. angustus</i>	<i>I. pacificus</i>	<i>I. spinipalpis</i>
Pathogen	#Positive/#Tested	#Positive/#Tested	#Positive/#Tested
<i>Anaplasma phagocytophilum</i>	0/492	7/764 (0.9%)	2/13 (15.4%)
<i>Borrelia</i> species	0/43	3/87 (3.4%)	0/2
<i>Borrelia bissettiae</i>	0/1	0/27	0
<i>Borrelia burgdorferi</i> s.l.	15/437 (3.4%)	19/805 (2.4%)	1/15 (6.7%)
<i>Borrelia burgdorferi</i> s.s.	0/87	0/113	0/4
<i>Borrelia lanei</i>	0/1	0/27	0
<i>Borrelia miyamotoi</i>	0/221	0/376	0/7

Suppl. Table 2. Pathogens detected in *Dermacentor* species ticks collected from hosts or opportunistically at unknown locations in Washington, 2012-2016.*

	<i>D. andersoni</i>	<i>D. variabilis</i>
Pathogen	#Positive/#Tested	#Positive/#Tested
<i>Francisella tularensis</i>	0/211	1/396 (0.25%)
<i>Rickettsia</i> species	0/211	10/515 (1.9%)
<i>Rickettsia bellii</i>	0/0	7/64 (10.9%)
<i>Rickettsia montanensis</i>	0/32	4/136 (2.9%)
<i>Rickettsia peacocki</i>	5/32 (15.6%)	8/12 (66.7%)
<i>Rickettsia rhipicephali</i>	1/32 (3.1%)	0/136

**Dermacentor* species ticks were not actively collected until 2012.

Suppl. Table 3. Pathogens detected in unfed *Ixodes* species ticks collected in Washington State by county, 2010-2016.

		<i>I. angustus</i>	<i>I. pacificus</i>	<i>I. spinipalpis</i>
Pathogen*	County	#Pos/#Tested	#Pos/#Tested	#Pos/#Tested
<i>Anaplasma phagocytophilum</i>	TOTAL	0/95	5/269 (1.9%)	1/219 (0.5%)
	Clallam	0/24	4/94 (4.3%)	0/37
	Jefferson	0/0	0/1	0/0
	Mason	0/13	0/16	1/46 (2.2%)
	Yakima	0/0	1/3 (33.3%)	0/0
	King	0/11	0/0	0/0
	Klickitat	0/0	0/55	0/0
	Pierce	0/19	0/3	0/115
	Pacific	0/1	0/0	0/0
	Thurston	0/27	0/97	0/21
	Yakima	0/0	1/3 (33.3%)	0/0
<i>Borrelia</i> species**	TOTAL	1/98 (1.0%)	5/390 (1.3%)	2/220 (0.9%)
	Clallam	0/26	3/139 (2.2%)	0/37
	Jefferson	0/0	0/1	0/0
	King	0/11	0/0	0/0
	Klickitat	0/0	0/115	0/0
	Mason	1/13 (7.7%)	0/19	2/47 (4.3%)
	Pacific	0/1	0/0	0/0
	Pierce	0/19	0/3	0/115
	Thurston	0/28	2/110 (1.8%)	0/21
	Yakima	0/0	0/3	0/0
<i>Borrelia bissettiae</i>	TOTAL	0/41	0/205	1/64 (1.6%)
	Clallam	0/24	0/68	1/36 (2.8%)
	Klickitat	0/0	0/54	0/0
	Mason	0/4	0/3	0/9
	Pacific	0/1	0/0	0/0
	Pierce	0/1	0/0	0/0
	Thurston	0/11	0/77	0/19
	Yakima	0/0	0/3	0/0

Suppl. Table 3. Continued.

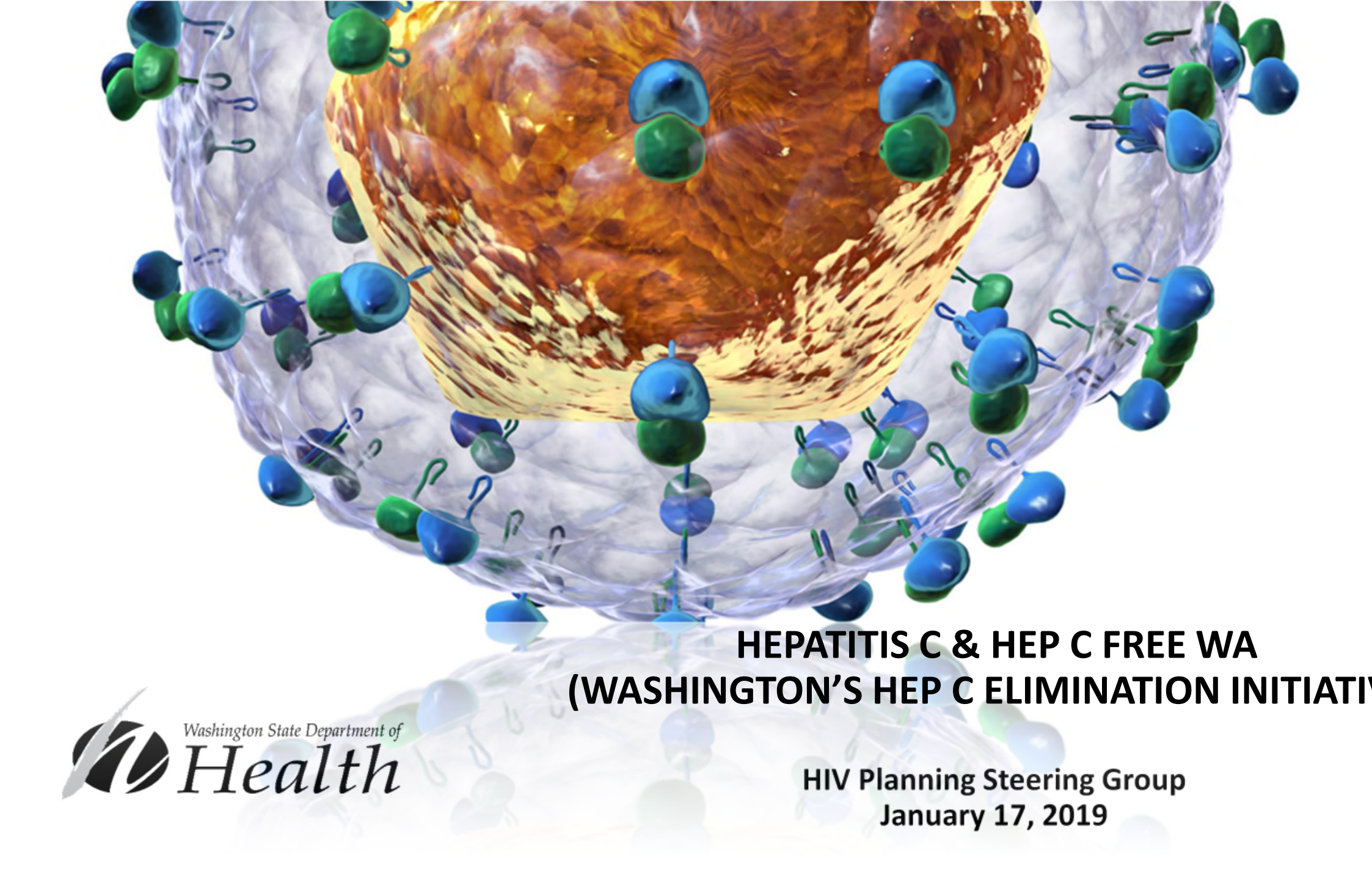
		<i>I. angustus</i>	<i>I. pacificus</i>	<i>I. spinipalpis</i>
Pathogen	County	#Pos/#Tested	#Pos/#Tested	#Pos/#Tested
<i>Borrelia burgdorferi</i> s.l.	TOTAL	1/99 (1.0%)	32/432 (7.4%)	6/220 (2.7%)
	Clallam	0/26	29/160 (18.1%)	4/37 (10.8%)
	Jefferson	0/0	0/1	0/0
	King	0/11	0/0	0/0
	Klickitat	0/0	0/118	0/0
	Mason	1/13 (7.7%)	0/19	2/47 (4.3%)
	Pacific	0/1	0/0	0/0
	Pierce	0/19	0/3	0/115
	Thurston	0/29	2/128 (1.6%)	0/21
	Yakima	0/0	0/3	0/0
<i>Borrelia burgdorferi</i> s.s.	TOTAL	0/45	15/354 (4.2%)	1/66 (1.5%)
	Clallam	0/26	12/121 (9.9%)	1/37 (2.7%)
	Klickitat	0/0	2/117 (1.7%)	0/0
	Mason	0/4	0/6	0/10
	Pacific	0/1	0/0	0/0
	Pierce	0/1	0/0	0/0
	Thurston	0/13	0/107	0/19
	Yakima	0/0	1/3 (33.3%)	0/0
<i>Borrelia lanei</i>	TOTAL	0/41	0/205	2/64 (3.1%)
	Clallam	0/24	0/68	2/36 (5.6%)
	Klickitat	0/0	0/54	0/0
	Mason	0/4	0/3	0/9
	Pacific	0/1	0/0	0/0
	Pierce	0/1	0/0	0/0
	Thurston	0/11	0/77	0/19
	Yakima	0/0	0/3	0/0
<i>Borrelia miyamotoi</i>	TOTAL	0/42	10/227 (4.4%)	0/69
	Clallam	0/24	7/80 (8.8%)	0/37
	Jefferson	0/0	0/1	0/0
	Klickitat	0/0	1/54 (1.9%)	0/0
	Mason	0/4	0/4	0/12
	Pacific	0/1	0/0	0/0
	Pierce	0/1	0/1	0/0
	Thurston	0/12	2/84 (2.4%)	0/20
	Yakima	0/0	0/3	0/0

*14 ticks identified only to *Ixodes* genus and 10 *I. texanus* were tested for *A. phagocytophilum*, *B. burgdorferi*, and *Babesia* species – all were negative.

**One of four *I. auritulus* collected in Clallam County tested positive for *Borrelia* species, but because CDC's tick DNA primer/probe set did not detect *I. auritulus*, they could not control for DNA quality.

Suppl. Table 4. Pathogens detected in field-collected *Dermacentor* species ticks in Washington State by county, 2012-2016.

		<i>D. andersoni</i>	<i>D. variabilis</i>
<i>Pathogen</i>	County	#Pos/#Tested	#Pos/#Tested
<i>Rickettsia species</i>	TOTAL	0/26	2/46 (4.3%)
	Asotin	0/1	0/0
	Benton	0/0	0/3
	Chelan	0/1	0/0
	Ferry	0/1	0/0
	Franklin	0/0	0/1
	Grant	0/0	0/15
	King	0/0	0/1
	Kittitas	0/1	0/0
	Klickitat	0/1	1/12 (8.3%)
	Lincoln	0/15	0/3
	Skamania	0/0	0/1
	Spokane	0/5	1/8 (12.5%)
	Yakima	0/0	0/2
<i>Rickettsia peacocki</i>	TOTAL	8/22 (36%)	2/42 (4.8%)
	Benton	0/0	0/3
	Ferry	0/1	0/0
	Franklin	0/0	0/1
	Grant	0/0	1/15 (6.7%)
	Kittitas	1/1 (100.0%)	0/0
	Klickitat	0/0	0/11
	Lincoln	6/15 (40.0%)	0/3
	Skamania	0/0	0/1
	Spokane	1/5 (20.0%)	1/8 (12.5%)
<i>Rickettsia rhipicephali</i>	TOTAL	2/22 (9.0%)	1/42 (2.4%)
	Benton	0/0	0/3
	Ferry	0/1	0/0
	Franklin	0/0	0/1
	Grant	0/0	0/15
	Kittitas	0/1	0/0
	Klickitat	0/0	1/11 (9.1%)
	Lincoln	2/15 (13.3%)	0/3
	Skamania	0/0	0/1
	Spokane	0/5	0/8



**HEPATITIS C & HEP C FREE WA
(WASHINGTON'S HEP C ELIMINATION INITIATIVE)**



HIV Planning Steering Group
January 17, 2019

Objectives to provide HPSG with:

1. A brief overview of what the hepatitis C virus (HCV) is and how it is transmitted.
2. A brief overview of the Washington State HCV epidemiology and the populations most impacted by HCV.
3. Information about how HIV and HCV are syndemics, or overlapping epidemics, and how efforts to address HIV may be leveraged to address both HIV and HCV.
4. A description of the Governor's Directive related to HCV elimination and the work to develop an elimination plan by July.

What is “hepatitis”?

Hepa-

- Liver (Greek)
- The liver is your body’s filter and has a role in metabolism

-itis

- Inflammation (Greek)

Many causes of hepatitis, for example:

- Autoimmune
- As a result of medications, drugs, toxins, alcohol
- **Viruses**
 - **When caused by a virus the word “hepatitis” is followed by a letter (A, B, C, D, E)**

Hepatitis ABCs



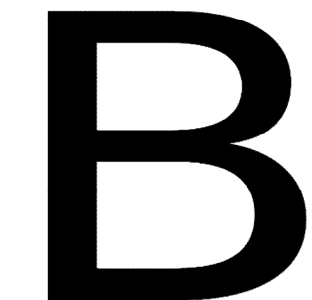
Vaccine preventable.

Transmitted by oral-fecal contact (e.g., contaminated food/water, rimming).

Acute illness that rarely causes mortality.

Outbreaks were rare in the United States, but in the last two years outbreaks have emerged in a number of states.

“A is for...”



Vaccine preventable.

Transmitted like HIV (sexual fluids, blood, breast milk). In highly endemic areas (e.g., parts of Asia and Africa), most common route is mother-to-child.

For those who do not naturally “clear” the virus, HBV is chronic.

Not everyone needs treatment, but for those who do it is generally lifelong.

Can lead to chronic liver disease, liver cancer, and mortality.

“B is for...”

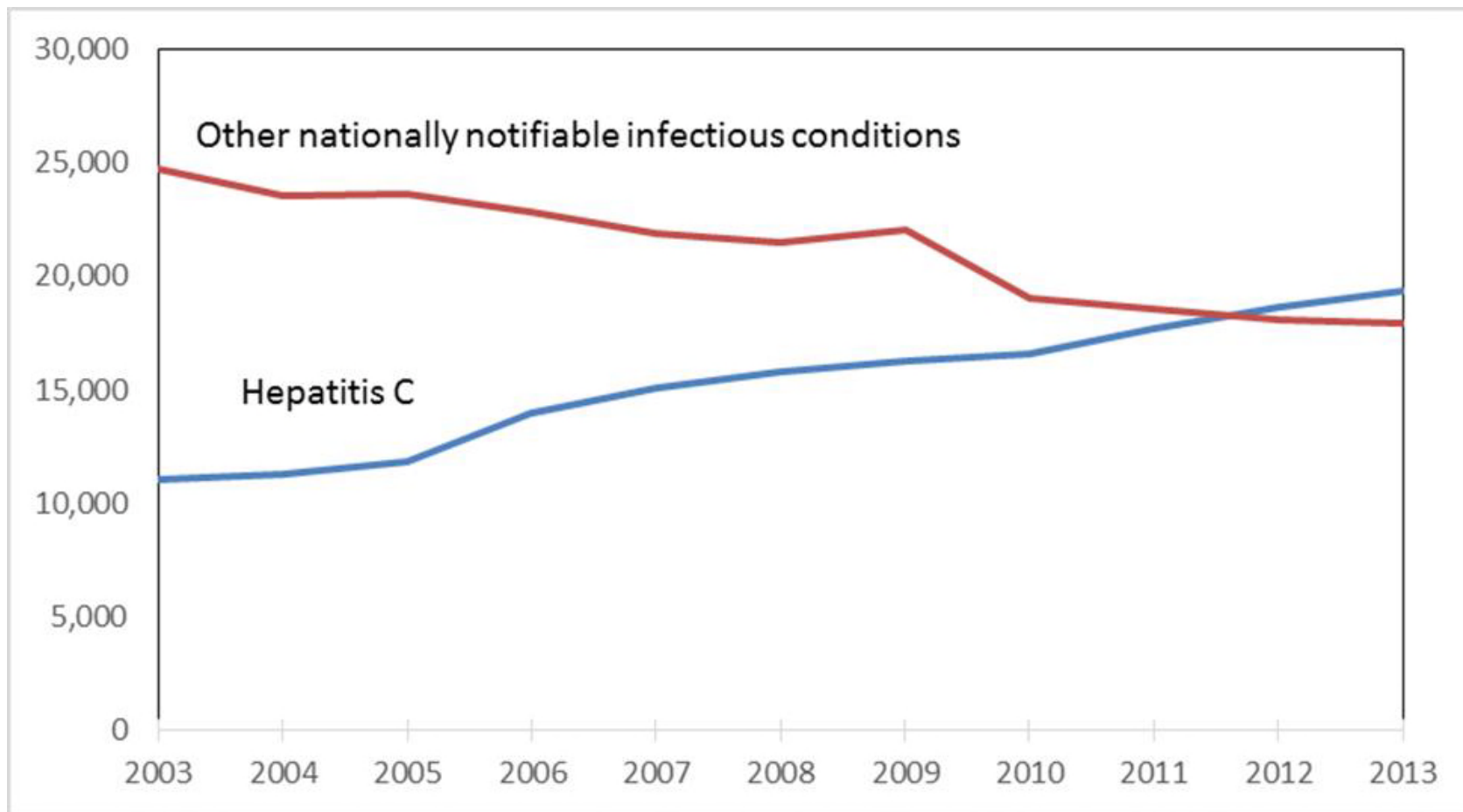
Hepatitis C

- No vaccine for prevention.
- Primarily transmitted by blood-to-blood contact.
- About 25% of people who acquire HCV naturally “clear” the virus – for those who do not the virus is chronic.
- HCV treatment is indicated for nearly everyone living with the virus.
- Medications called “direct acting antivirals” or “DAAs” taken for as little as 8-12 weeks to **cure the virus** in almost everyone living with HCV (for most people treatment has few minor or no side effects).
- “C is for...”

HCV in the United States

- HCV is the most common bloodborne infection in the United States.
- At least 2.4 million people in the US living with HCV (likely higher).
- Leading cause of liver cancer and leading indication for liver transplant in the US.
- Rising death and morbidity in the aging Baby Boomer (born between 1945 through 1965) population.
- Disproportionately affects underserved/marginalized/stigmatized populations:
 - People who inject drugs (PWID), people living with HIV(PLWH), incarcerated individuals, low-income communities, and people of color.

CV Deaths Exceed Deaths from 59 Other Infectious Diseases Combined



Other notifiable infectious conditions include HIV, tuberculosis, and hepatitis B (source: CDC)

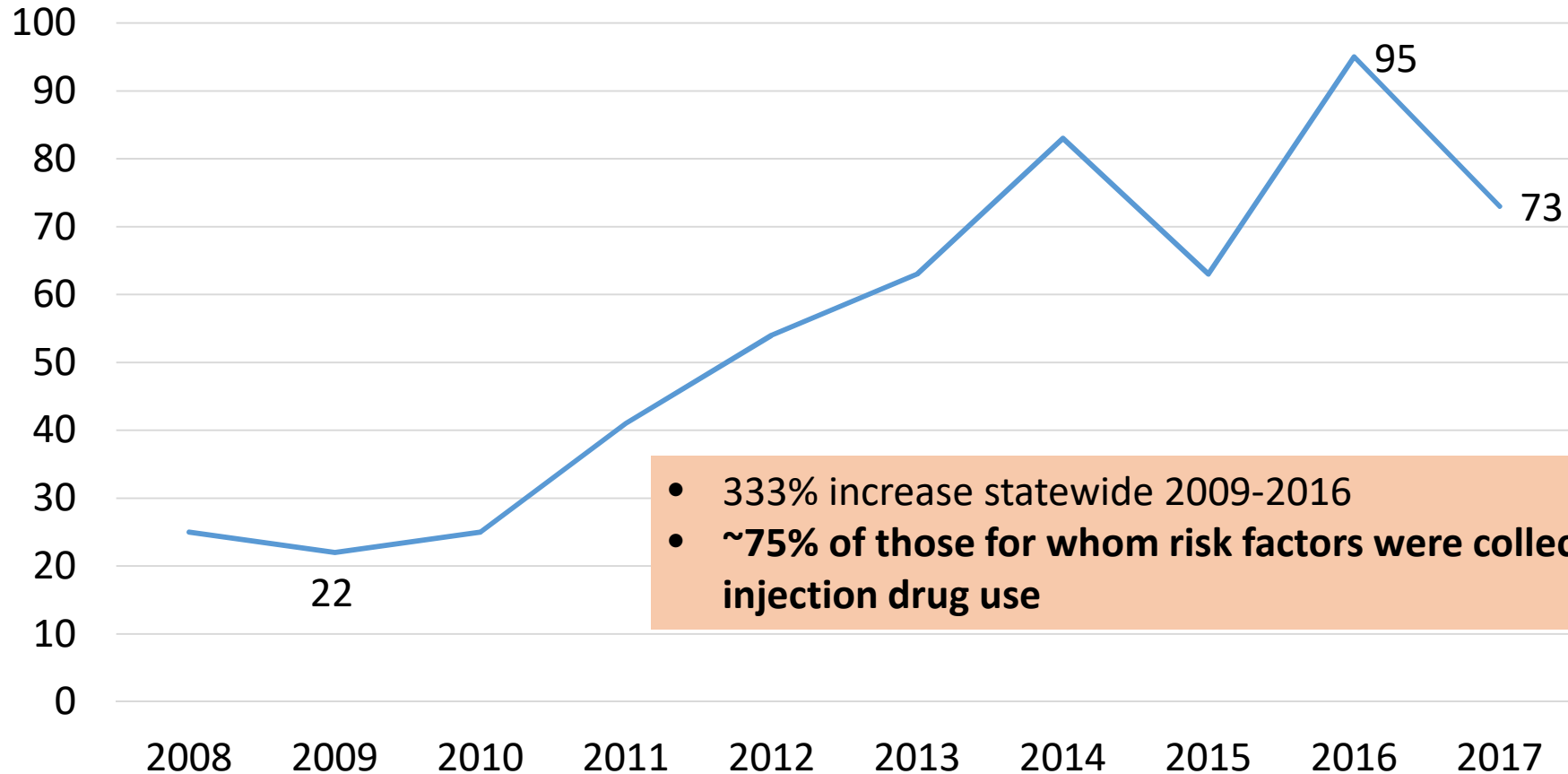
HCV Surveillance in Washington State

- Estimated 65,000 Washingtonians living with HCV in 2016 (Centers for Disease Analysis)
- Hospitalization costs related to HCV in Washington were \$114 million from 2010 through 2014.
- In 2017:
 - 8,839 new reports of chronic infection
 - 543 deaths attributed to chronic HCV
 - 73 new reports of acute infection

Newly Reported HCV cases			
Year	Acute	Chronic	Total
2012	54	4,865	4,919
2013	63	4,438	4,501
2014	83	5,995	6,078
2015	63	7,085	7,148
2016	95	8,118	8,213
2017	73	8,839	8,912

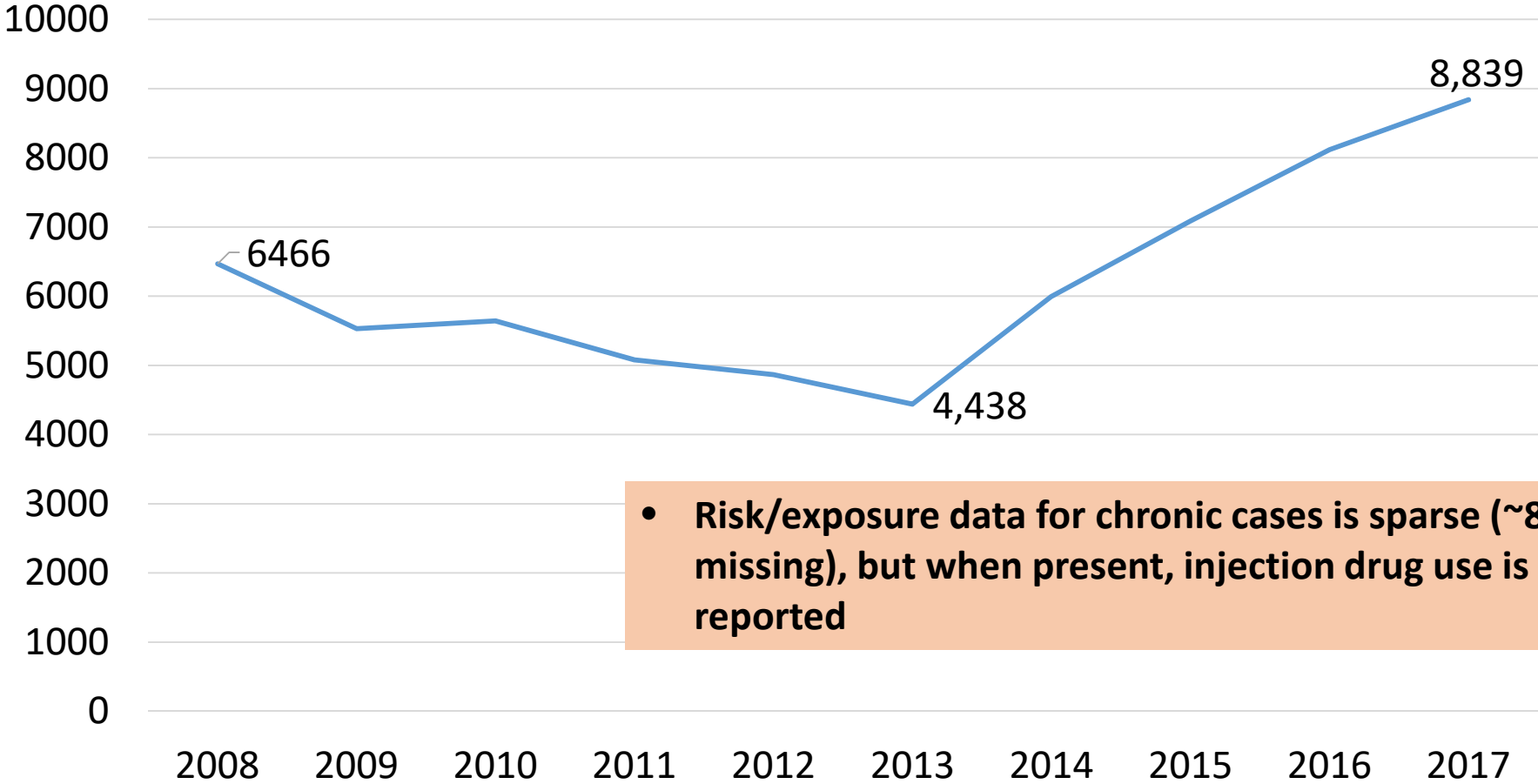
Source: WA DOH Hepatitis Surveillance Records

Acute HCV cases in Washington State, by year of report (2008 – 2017)



Source: WA DOH Hepatitis Surveillance Records

Chronic HCV cases in Washington State, by year of report (2008 – 2017)



Source: WA DOH Hepatitis Surveillance Records

Age shift among chronic cases

2007		
Age range	#	%
0-9	18	0.3
10-19	53	1.0
20-29	378	6.9
30-39	752	13.7
40-49	1701	31.1
50-59	2050	37.5
60-69	392	7.2
70-79	94	1.7
80+	36	0.7
unknown	22	
Total	5496	

Baby Boomer cohort

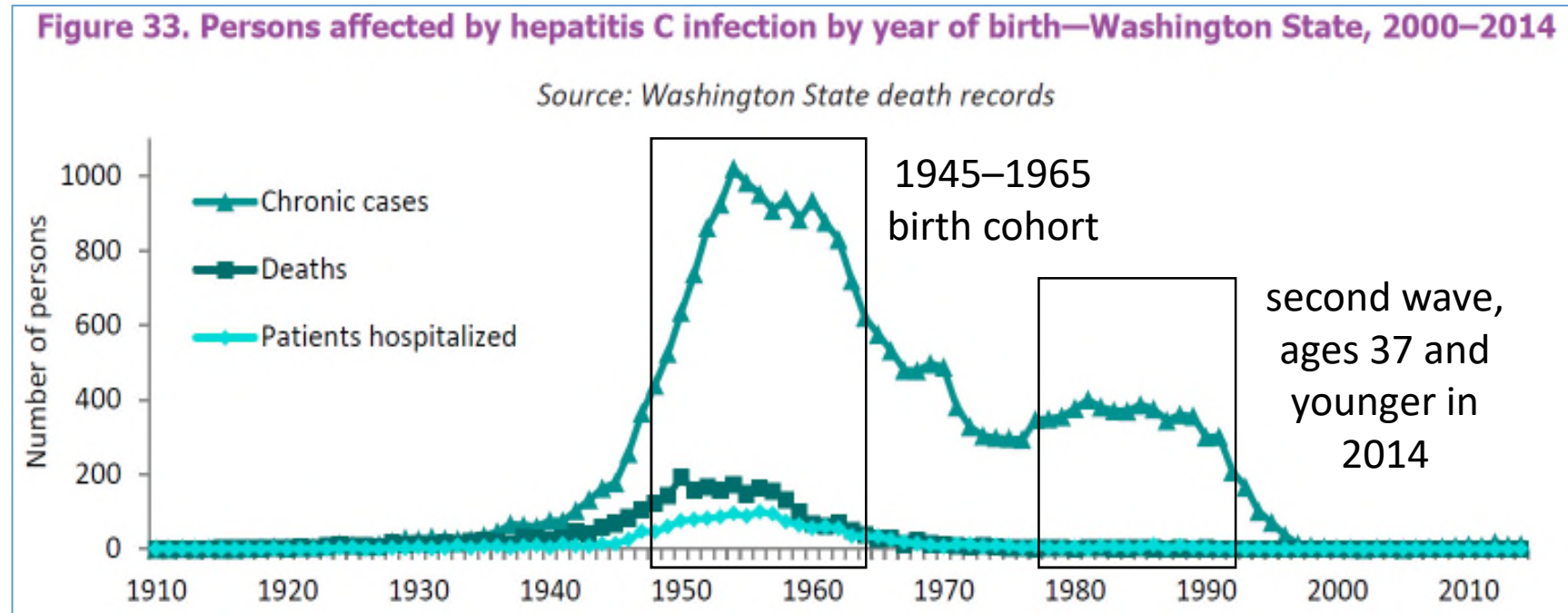


2017		
Age range	#	%
0-9	30	0.3
10-19	106	1.2
20-29	1255	14.2
30-39	1349	15.3
40-49	1097	12.5
50-59	2270	25.8
60-69	2294	26.0
70-79	353	4.0
80+	59	0.7
unknown	26	
Total	8839	

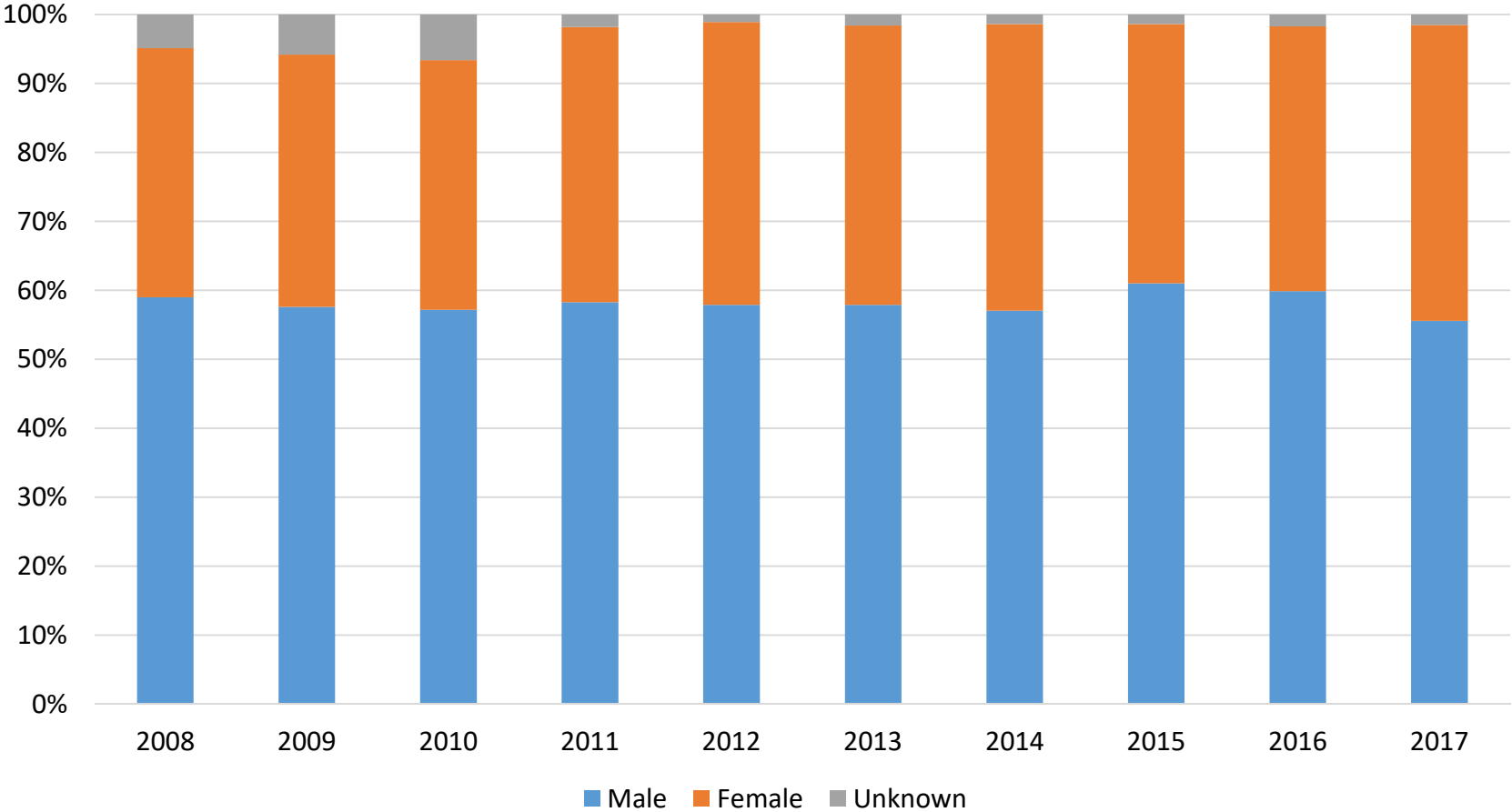
Source: WA DOH Hepatitis Surveillance Records

HCV by Year of Birth

The Tale of 2 Epidemics

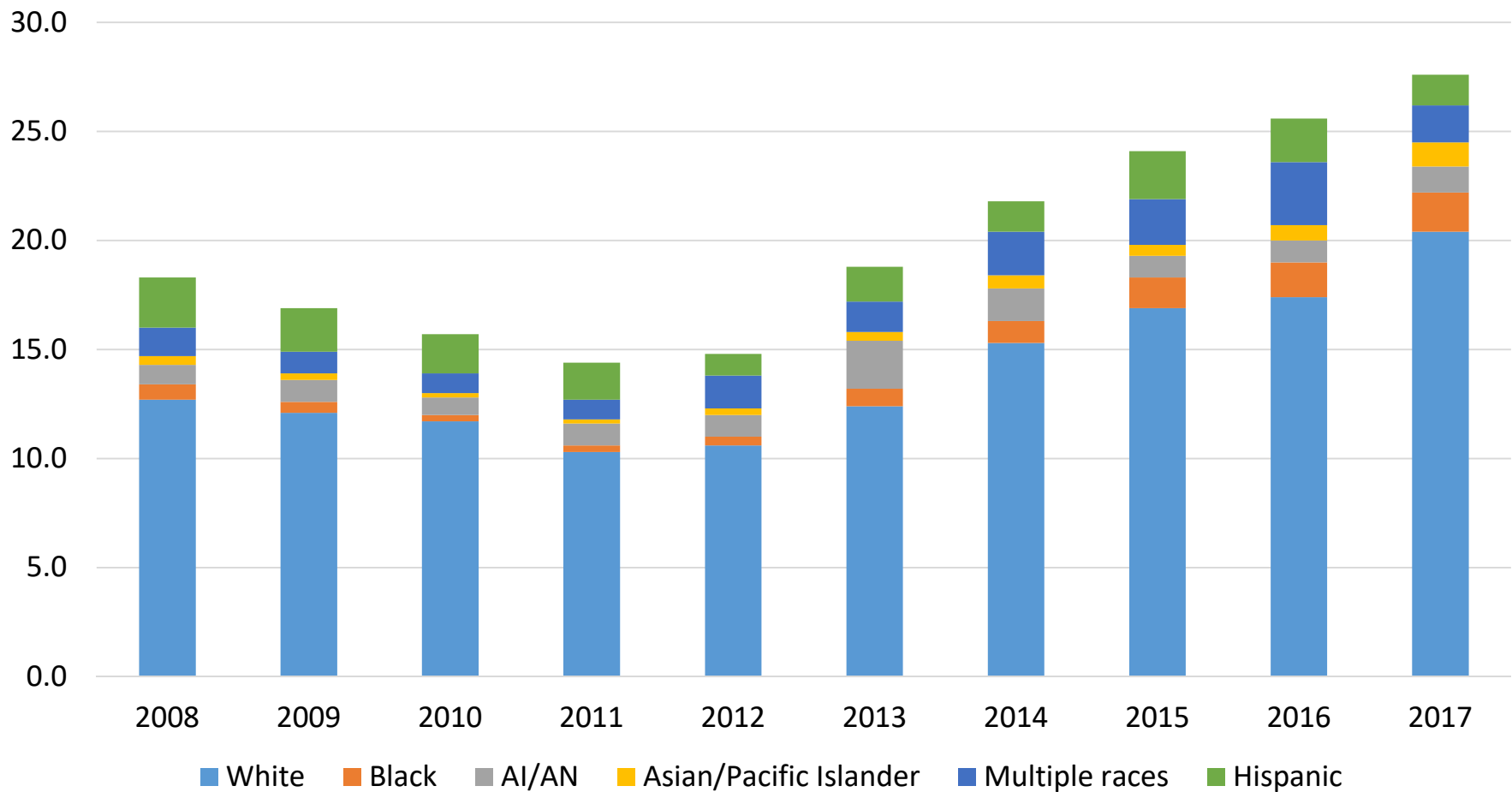


Gender Breakdown of Chronic HCV Cases Washington State, 2008-2017



Source: WA DOH Hepatitis Surveillance Records

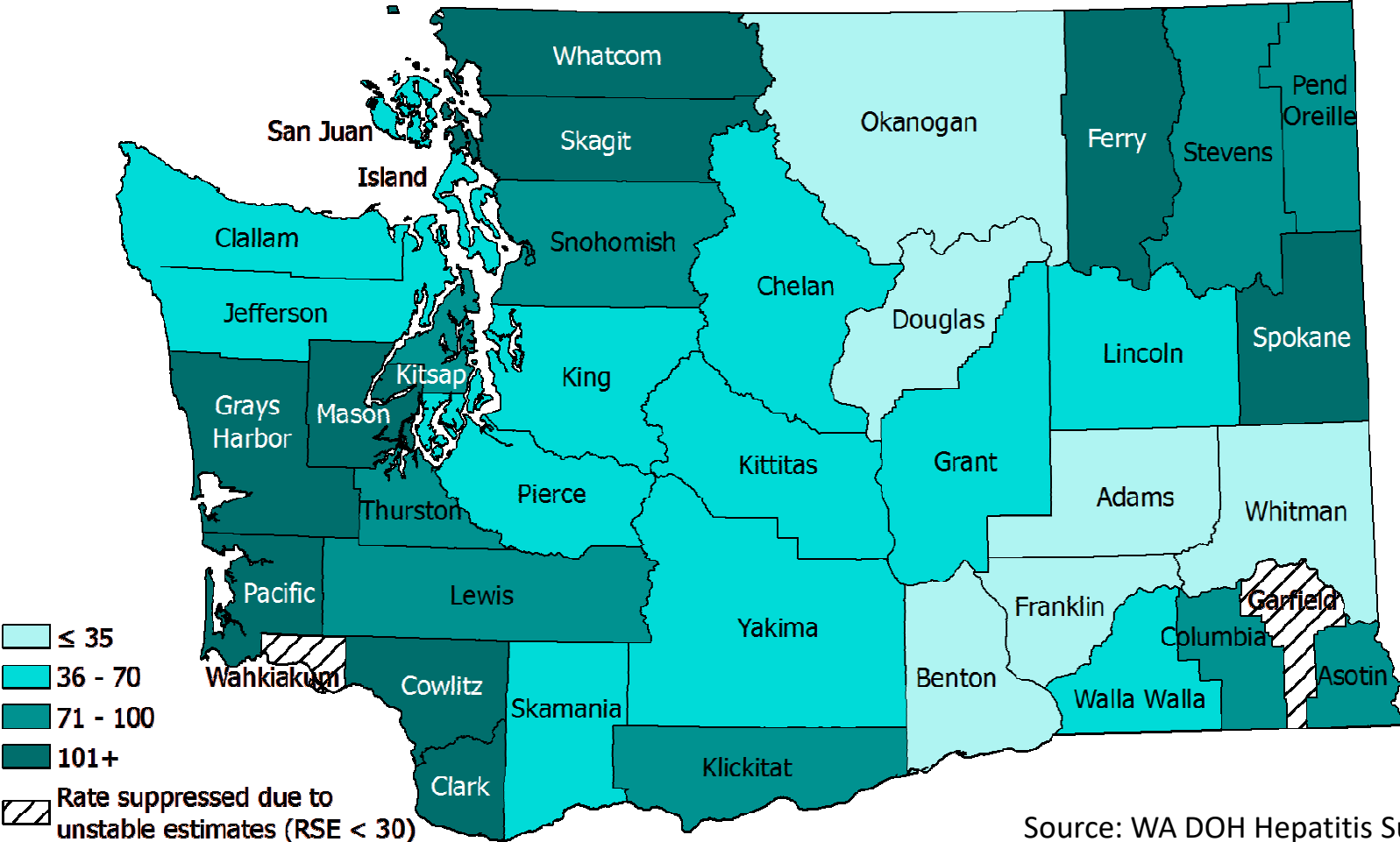
Race/Ethnicity Breakdown of Chronic HCV Cases Washington State, 2008-2017*



average, ~75% of records are missing race/ethnicity data

Source: WA DOH Hepatitis Surveillance Records

e-year rate of chronic HCV infections per 100,000 persons among non-incarcerated residents—Washington State, 2010-2014



Source: WA DOH Hepatitis Surveillance Records

Limitations of HCV Surveillance in Washington State

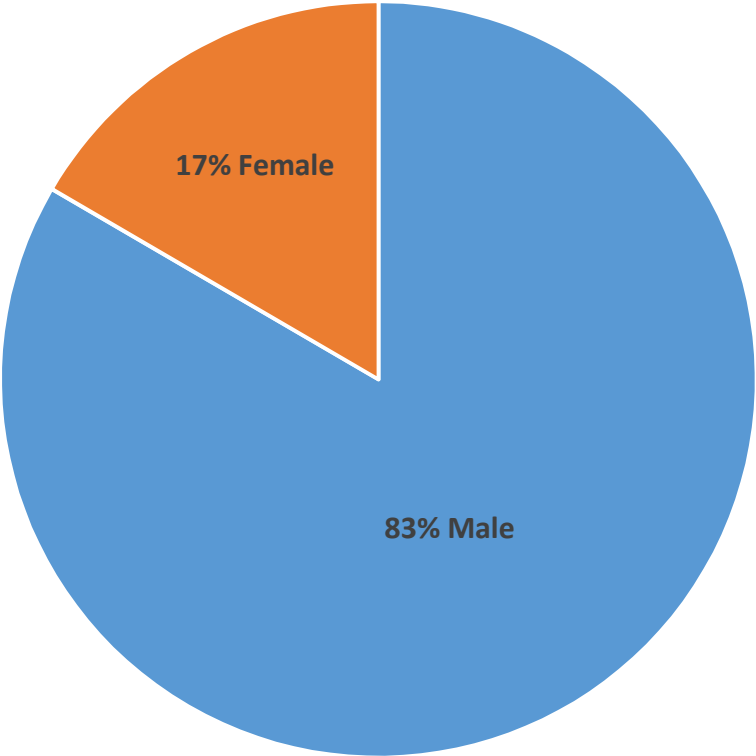
- **General lack of resources at both the state and local level:**
 - Most LHJ staff work on all communicable diseases; dedicated hepatitis staff at just 3 largest LHJs
- **Unable to accurately track patients in the registry who have:**
 - Moved out of state
 - Died
 - Cleared their infections
 - Been cured
- **Other limitations include:**
 - ~75% of risk (and race/ethnicity) data among known chronic cases are missing
 - Diagnoses missed due to asymptomatic nature of disease
 - Some Baby Boomers not being appropriately screened
 - Limited in ability to conduct partner/contact investigations

The relationship between HIV and HCV in the U.S.

- **Approximately 25% of PLWH in the US have past or present HCV infection.**
 - HIV coinfection more than triples the risk for liver disease, liver failure, and liver-related death from HCV.
 - Gay, bisexual, and other men who have sex with men living with HIV are at particular risk for sexual transmission of HCV (risk factors include unprotected anal sex, fisting, presence of STDs, use of certain sex toys, and non-injection drug use).
- **PWID who share needles, syringes, or any other drug-injection equipment represent a growing number of new HIV and HCV infections.**
 - As a result of the expanding epidemic of injection opioid and other drug use, PWID are increasingly at risk for HIV/HCV coinfection, as evidenced by the recent outbreak of HIV in Scott County, Indiana. 215 persons were found to be infected with HIV in Scott County, more than 90% of whom were already infected with HCV.
 - High rates of HCV in a community can serve as an early warning signal of increased drug use and transmission of other blood borne viruses, including HIV.
 - Preventing HCV among PWID also serves a strong HIV prevention function.

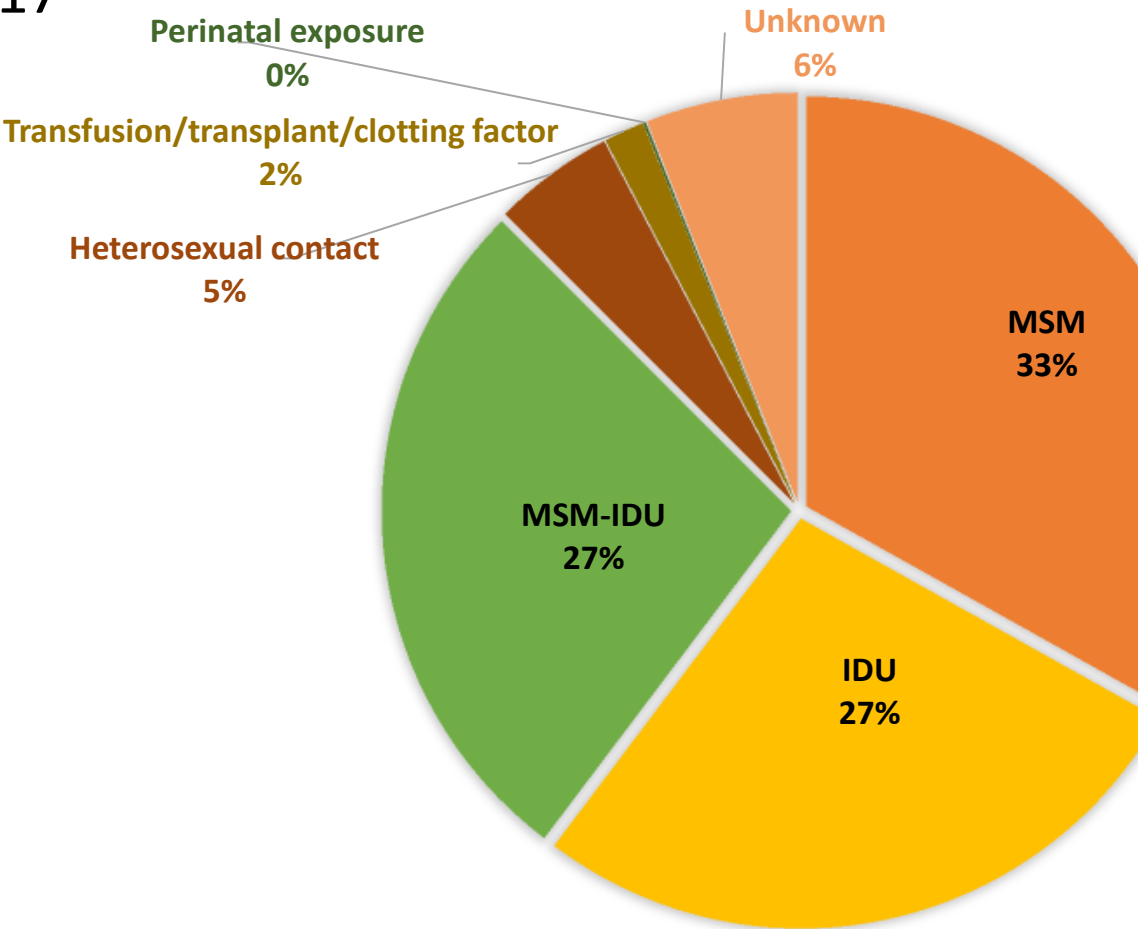
HIV and HCV co-infection in Washington State

10% of PLWH living in WA at the end of 2017 were co-infected with HCV (*caveats*)

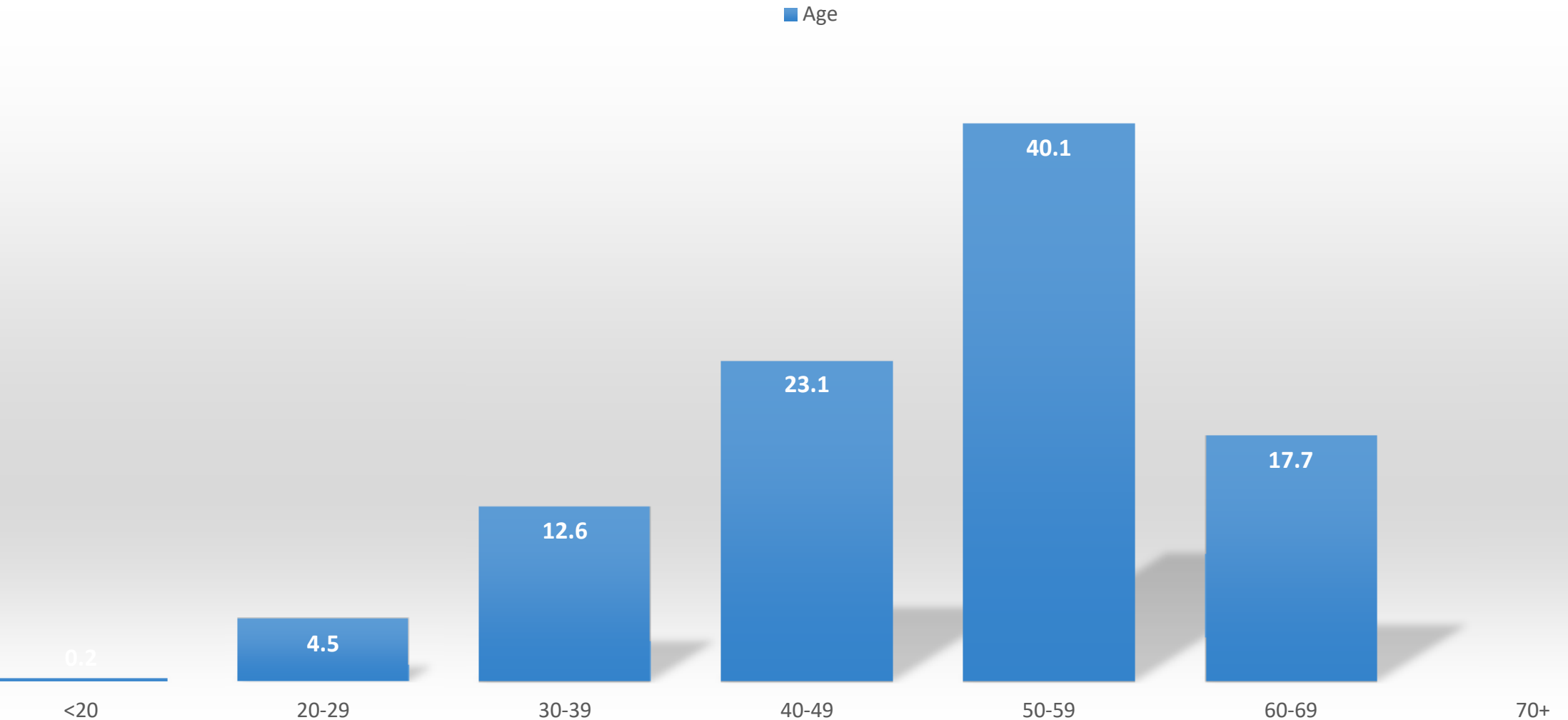


Source: WA DOH HIV Surveillance and Hepatitis Surveillance Records)

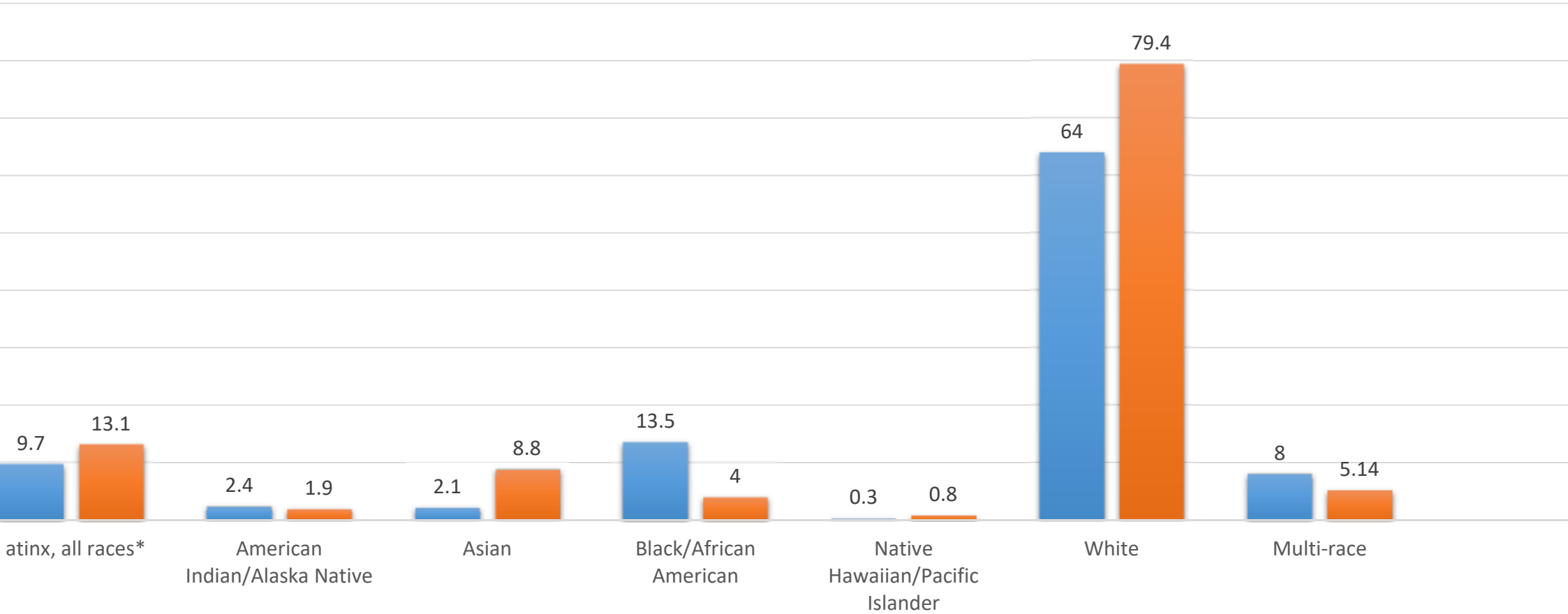
RISK CATEGORY (FROM HIV DATA)



HIV/HCV co-infection by age, Washington State, 2017



HIV/HCV co-Infection by race/ethnicity, Washington State, 2017



*Latinx population data for 2018
Office of Financial Management,
or Latinx is collected separate
race data*

■ Co-infected ■ Population in WA 2018

Global and U.S. Conversations about HCV Elimination - Why Now?



- The clock is ticking as HCV-related mortality rises.
- Almost all people with HCV can be cured with a short-course (8-12 weeks), well-tolerated, all-oral treatment.
- All people with HCV can benefit from a cure.
- HCV Cure as HCV Prevention: Scaled up HCV treatment paired with prevention of reinfection can lead to HCV elimination.
- Examples to build from, including HHS “National Viral Hepatitis Action Plan”, NASEM “A National Strategy for Elimination of Hepatitis B and C”, and Tribal, state, and local efforts

What makes HCV elimination possible in Washington State?

- HIV program infrastructure (End AIDS WA), including testing, linkage to care services, case management, STD/HIV disease intervention services, etc.
- Drug user health infrastructure, including access to syringe service programs and medication assisted treatment for opioid use.
- Small but mighty group of committed medical providers willing to treat and cure HCV.
- Academic institutions with clinicians and educators studying HCV interventions and building provider capacity.
- Medicaid expansion and a Medicaid HCV policy that makes it possible to treat the majority of Medicaid beneficiaries living with HCV.
- AIDS Drug Assistance Program that supports HCV treatment for people who are living with HIV and HCV (should be relatively easy to eliminate HCV among PLWH).
- Improving HCV surveillance and assessment efforts.
- CDC support for some HCV programming and surveillance.

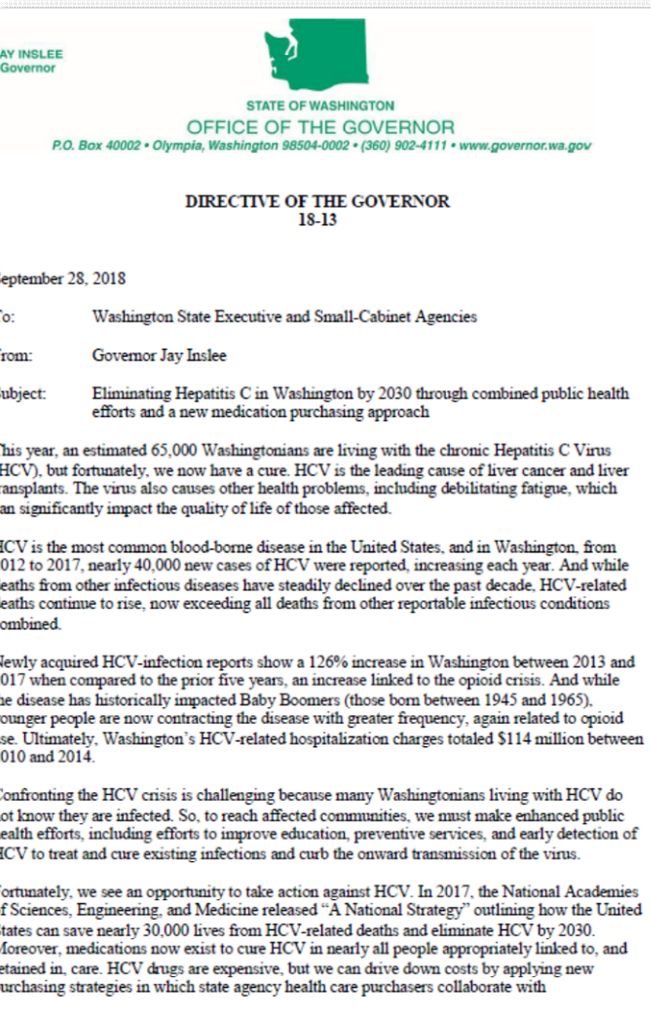
Potential barriers to HCV elimination in Washington State

- Increasing homelessness and displacement.
- Increasing incidence of HCV among young people who inject drugs.
- Racial disparities in HCV case reporting.
- Many primary care providers not yet ready or willing to treat and cure HCV in their practices.
- Limited federal investment in viral hepatitis surveillance, prevention, testing, and treatment interventions.

History of how we got here

- 1998** – Advocates press for a state response to HCV
- 2003** – Bill passed requiring DOH to develop an HCV strategic plan
- 2004** – DOH develops first Washington State HCV strategic plan
- 2006** – Funding for HCV response is included in state budget for the first time
- 2014** – DOH develops a second Washington State HCV strategic plan
- 2018** – Internal state cross-agency work group starts discussing elimination in spring, meeting regularly from June through September 2018
 - *Department of Corrections*
 - *Department of Health*
 - *Department of Labor & Industries*
 - *Department of Social & Health Services*
 - *Health Care Authority*
 - *Office of Financial Management*
 - *Office of the Governor*
 - *Office of the Insurance Commissioner*

Governor Inslee Issued Directive on September 28, 2018 to Eliminate HCV in Washington by 2030



Statewide HCV elimination plan



- DOH, in collaboration with any other relevant state agencies that it identifies, shall convene and facilitate an HCV elimination coordinating committee comprised of stakeholders from various sectors, including individuals personally affected by HCV.
- **The committee shall draw on existing efforts, best practices, and community knowledge to develop, by July 2019, a comprehensive strategy to eliminate the public health threat of HCV in Washington by 2030.**
- The strategy will address needed improvements to the public health systems to help ensure that all people living in Washington who have or are at risk for contracting HCV, have access to preventive services, know their status, and connect to care and ultimately the cure.
- The elimination strategy shall include a major public health communications plan financed, to the extent possible, by the funds saved through the purchasing strategy described in the next two slides.

Innovative drug procurement strategy

- Innovative drug procurement strategy being led and coordinating by Health Care Authority.
- First-in-nation comprehensive procurement of HCV medications purchased by state agencies to get the best prices possible from manufacturers and make sure curative treatment is more readily available to all.

Defining HCV elimination*

A state where HCV is no longer a public health threat and where those few who become infected with HCV learn their status quickly and access curative treatment without delay, preventing the forward spread of the virus.

****Elimination is distinct from eradication.** Eradication is reduction of the worldwide incidence of a disease to zero as a result of deliberate efforts, obviating the necessity for further control measures. True eradication usually entails eliminating the microorganism itself or removing it completely from nature.*

How to reach HCV elimination

The World Health Organization has set goal of HCV elimination by 2030:

- Increase syringe supply coverage from 20 sets per year per PWID at baseline (2015) to 300 sets per year per person who injects drugs
- 90% of those with HCV diagnosed
- 80% of those eligible treated for HCV by 2030
- 90% reduction in HCV incidence
- 65% reduction in HCV mortality

As the Hep C Free WA develops the state elimination plan, we will need to define process and outcome objectives for reaching HCV elimination.

WA DOH HCV Strategic Plan, 2014

primary areas around which recommended actions are grouped:

Identify people with HCV, link them to care, and get them to a cure

- Build a health care workforce prepared to diagnose, care for, treat and cure persons with HCV.
- Educate communities about risk factors for HCV, how to reduce risk, and availability of prevention, testing, and treatment services.
- Improve testing, care, and treatment and raise the bars along the care continuum.

Prevent new infections

- Ensure persons who inject drugs have access to screening, prevention, care, and treatment services.
- Mobilize a coordinated response to drug user health.
- Expand access to and delivery of hepatitis education and prevention services in correctional settings and beyond.

Strengthen data systems and increase data use

- Monitor HCV-associated transmission, disease, mortality, and health disparities.
- Monitor provision and impact of HCV prevention, treatment and care, highlighting population-specific differences in access to services.
- Develop and implement new regulations, technologies and lab procedures to improve surveillance.

WA DOH HCV Strategic Plan, 2014 *(continued)*

Some recommended actions are achievable with existing resources in the public health system; some may be achieved by leveraging resources and technology in other systems, primarily the health care delivery system; and some recommended actions will require additional investments, primarily in the area of scaling-up promising practices.

The sooner we act:

- The more people with long-standing infection we will save from life-threatening disease and death;
- The sooner we see returns on our investments in public health;
- The more new infections we will avert so another generation is not impacted by disease; and
- **The sooner we can eliminate HCV in Washington.**

WA DOH HCV prevention portfolio

disease detection & provider readiness

- Early adopters of rapid hepatitis C antibody screening technology
 - 2012, direct funding using General Fund State monies
 - Development of *WA State Hepatitis C Rapid Screening Program*
 - Community based organizations, local governmental health, and health care participants
 - Current Funding:
 1. Rapid screening tests,
 2. Health education,
 3. UW Project ECHO,
 4. Local county jail projects, and
 5. CHC / FQHC screening interventions.

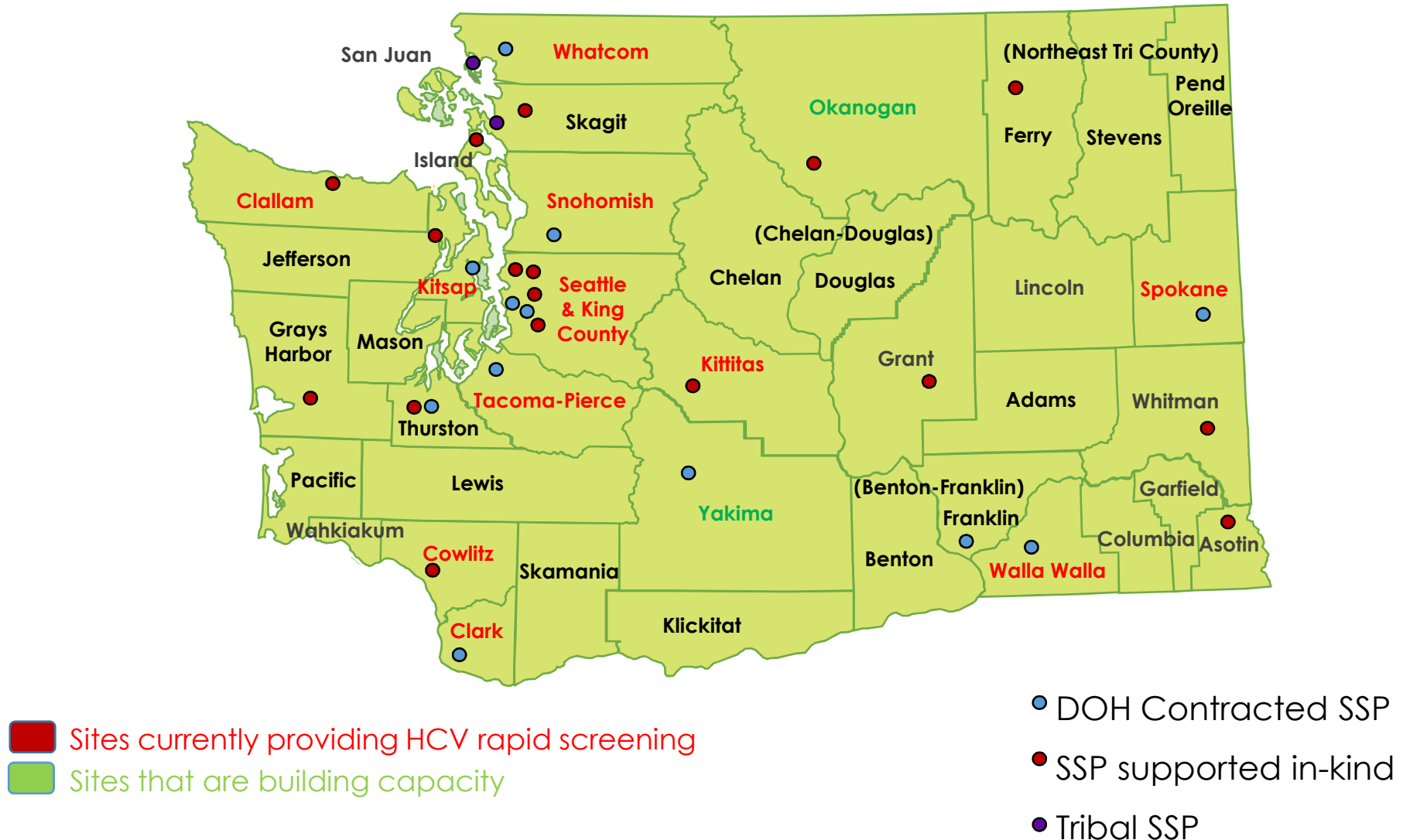
WA DOH HCV prevention portfolio

syringe service programs

- Started in response to the HIV epidemic and its impact on people who inject drugs (PWID) in United States.
- Washington State is home to the first publicly funded SSP in US:
 - **1988**: Tacoma Needle Exchange/Point Defiance AIDS Project in partnership with Tacoma-Pierce County Health Department
- Washington State SSP Funding:
 - **1992**: first direct funding using General Fund State monies
 - Current investments:
 - 11 programs receive a total of \$1.3 million for FTE, screening, rent of space, etc.
 - ~30 programs receive injection equipment (e.g., needles, cottons, cookers)

WASHINGTON STATE SYRINGE SERVICE PROGRAMS

HCV Screening Sites



Collective impact involves a group of people getting together to work on a complex issue, under five conditions:



Three elements for successful collective impact

existing public health efforts to prevent and detect HCV.
treatments that cure HCV in almost everyone affected in as little as 8 weeks.
significant morbidity and mortality related to HCV.
treatments and hospitalizations related to HCV taxing public resources.

Agency
change



- Multiple state agencies and public and private partners willing to devote staff time and resources to HCV elimination.
- Seeking financing for this effort through various channels.

Resources



- Governor Inslee!
 - Governor's Health Sub-Cabinet
 - Health & Human Service Agency Leadership

Influential
champion



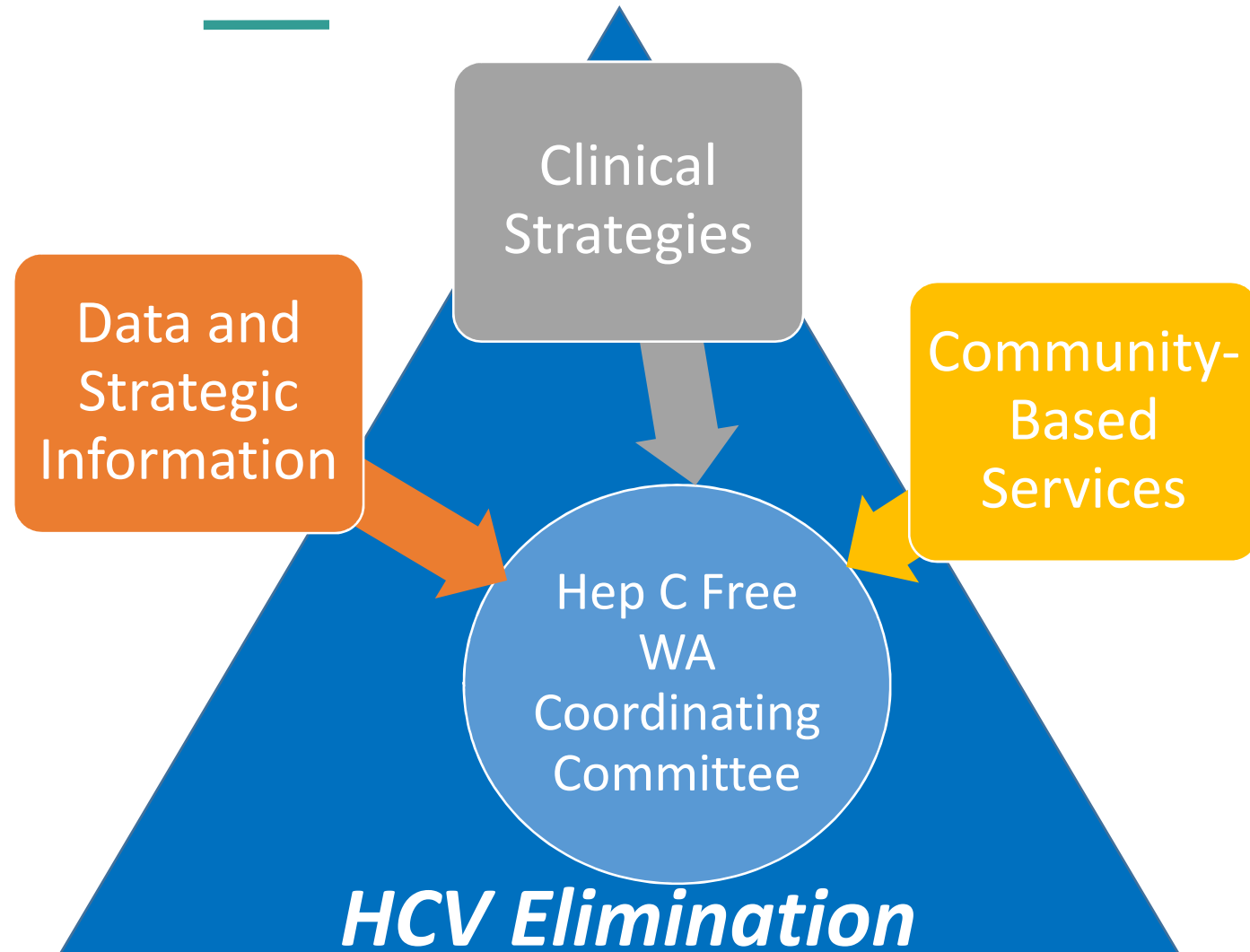
Hep C Free WA Coordinating Committee

Includes representatives from:

- State agencies and offices (DOH, HCA, DOC, OFM, LNI, etc.)
- Tribal health centers
- Local health jurisdictions
- Federally qualified health centers
- Community-based organizations
- Syringe service programs
- Opioid treatment programs
- Veterans Administration
- Academic institutions (UW, WSU)
- Health plans
- Professional organizations
- People affected by HCV

Hep C Free WA

Three topic-specific work groups will make recommendations to the Coordinating Committee for what should be included in the plan to eliminate HCV by 2030



I to deliver the plan to eliminate HCV in WA by 2030 to the Governor



Appreciation

Hep C Free WA Coordinating Committee and Work Group members

Staff in the WA DOH Office of Infectious Disease, particularly:

- Assessment Unit staff, especially Tom Jaenicke, Tessa Fairfortune, Jen Lam, and Jen Reuer
- Hepatitis C & Drug User Health team, Jon Stockton, Willie Rhodes, Shana Paulsen, Sarah Deutsch

For more information

Washington State Department of Health, Hep C Free WA webpage:

[tps://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/Hepatitis/HepatitisC/EliminatingHepatitis](https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/Hepatitis/HepatitisC/EliminatingHepatitis)

Emalie Huriaux, MPH

STD, Adult Viral Hepatitis & Syringe Service Programs Manager

Washington State Department of Health

Emalie.Huriaux@doh.wa.gov

HIV in PWID Special Emphasis Workgroup

December 2018 – January 2019

DRAFT Recommendations to HPSG

Key points:

- The increase in new HIV infections among persons who inject drugs (PWID) in Seattle requires an immediate response to stem new infections and link people to care.
- This population includes, but is not limited to, people who use drugs, people living houseless, people engaging in sex work, and individuals indicating heterosexual sex.
- There are insufficient health care resources currently in place in the area in North Seattle most affected by the increase in HIV.
- There are potentially other resources besides HIV funding to improve health care and behavioral health services for this population some primary needs in addition to HIV Prevention and Care Services include access to medication assisted treatment (MAT) for opioid use, STD testing and treatment, hepatitis C testing and treatment, and mental health services. The extent to which these resources can be marshaled to address the problem of HIV among PWID is not yet certain.

Short Term

- **PHSKC** is reallocating staff and funding to provide outreach testing and testing in the King County Jail
- **PHSKC** is working with emergency departments to increase HIV testing and with local healthcare organizations to identify opportunities to expand care for PWID who are living homeless
- **PHSKC** to look for alternative monies until July
- **PHSKC** to provide a budget for proposed activities to address the situation in north Seattle; such as jail testing in KC
- **SHE Clinic/UW** to continue to bill Medicaid for women to get them on meds to stretch funding already allocated to them
- **Aurora Commons** requested additional (1.0) FTE to increase work for female-identified participants and expand to work with male-identified participants
- **OID:** Considering request and problem solving contracting issue
- **OID:** Determine feasibility and necessity to quickly scale up HIV testing among PWID outside of King County
- **OID:** Reach out to HCA to determine if additional support for health care services can be provided
- **OID:** Send out a statewide alert to medical providers and social service organizations that serve PWID

Medium Term

- **OID:** Will update End AIDS Washington recommendations to reflect more up-to-date data/information about HIV among PWID in Washington
- **OID:** Assessment of how to improve access to HIV and HCV testing and HAV/HBV vaccination at syringe service programs throughout the state
- **OID:** Identify opportunities for financing syringe service programs to provide whole person health care to, and to manage the infectious disease consequences of, injection drug use.
- **OID:** Convene Epi group to evaluate scale of problem and needs – Landscape analysis to assess the size of the pop at risk, and the service needs. Shoot for a compressed timeline – convene in Jan or early Feb and have an initial report and plan for additional data collection and work by April 1.

HIV in PWID Special Emphasis Workgroup

December 2018 – January 2019

DRAFT Recommendations to HPSG

Long Term

- **PHSKC** to make recommendations to OID/DOH regarding funding including: payers, systems, agencies for a more comprehensive approach to clinical services for PWID in north Seattle
- **OID/PHSKC** look for resources to start a brick and mortar clinic in north Seattle
- **ALL:** Work on efforts to support expansion of the SHE Clinic to respond to the demand for health care in Aurora/northwest Seattle area

SEW Participants included:

Lisa Etter-Carlson and Sherice, Aurora Commons;

Shireesha Dhanireddy, Harborview Medical Center/SHE Clinic;

Matt Golden, Karen Hartfield, Joe Tinsley, Public Health – Seattle and King County;

Nicole Price – BABES;

Jason Sterne and Chelsie Porter, HEP Education Project;

Susan Kingston, University of Washington;

Beth Crutsinger-Perry, Tom Jaenicke, Emalie Hurlaux, Sarah Deutsch, Jen Reuer, Michael Barnes, Vanessa Leja, Washington State Department of Health, Office of Infectious Disease

Vaccine Inventory Update

1/17/2019

Last Update	Vaccine	Manufacturer	Brand	NDC Number	Presentation	UPDATE	ACTION	Alternative Products
1/17/2019	Hep B (Adult)	GSK	Engerix-B	58160-0821-52	10 pack - 1 dose syringe	Currently available in <u>both</u> DCs	NONE	NONE
1/16/2019	DTaP-IPV (Pediatric)	GSK	Kinrix	58160-0812-11	10 pack - 1 dose vial	Currently out of inventory in <u>Memphis</u> only	Please cancel all backorders. This product is no longer on the CDC contracts	58160-0812-52
12/3/2018	Hep A (Pediatric)	GSK	Havrix	58160-0825-11	10 pack - 1 dose vial	Currently out of inventory in <u>both</u> DCs	Please cancel all backorders. This product is no longer on the CDC contracts	58160-0825-52

To cancel orders, please contact McKesson: CDCCustomerService@McKesson.com						REMINDER: Based on the information in this table, ExIS awardees may need to update the list of NDCs in their ExIS (e.g., by manual entry into their ExIS or uploading the latest VTrckS federal vaccines list to their ExIS).		
For vaccine inventory questions, please email: vaccinedistributionc@cdc.gov						Contact the Vaccine Order Management Contact Center if you encounter problems with this activity: 1-877-878-6247 or vaccineordermgmt@cdc.gov .		

A green row signifies the addition of a product without any inventory issue.

Rows with no color signify a product with a depleted inventory or an inventory issue and alert you that action may need to be taken on your part.

Advance Bulk Purchase Update
Note:

The NDCs listed below are **currently not available** for placing bulk orders on the CDC contracts. Please contact your Vaccine Advisor for information about alternative products available for bulk order.

58160-0812-11 (PEDIATRIC) GSK Kinrix
 58160-0812-52 (PEDIATRIC) GSK Kinrix
 58160-0815-52 (PEDIATRIC & ADULT) GSK Twinrix
 58160-0818-11 (PEDIATRIC) GSK Hiberix
 58160-0823-11 Zoster (ADULT) GSK Shingrix
 58160-0819-12 Zoster (ADULT) GSK Shingrix
 58160-0820-52 Hep B (PEDIATRIC) GSK Engerix B
 58160-0825-11 (PEDIATRIC) GSK Havrix
 58160-0826-52 Hep A (ADULT) GSK Havrix
 00006-4841-41 Hep A (ADULT) Merck Vaqta
 00006-4096-02 Hep A (ADULT) Merck Vaqta
 00006-4981-00 Hep B (PEDIATRIC) Merck Recombivax HB
 00006-4093-02 Hep B (PEDIATRIC) Merck Recombivax HB
 00006-4094-02 Hep B (ADULT) Merck Recombivax HB
 00006-4995-41 Hep B (ADULT) Merck Recombivax HB

STD PCHD

**Strengthening STD Prevention and
Control for Health Departments**

STD PCHD 19-1901: Kickoff Webinar (Year 1)

January 17, 2019

Today's speakers:

Ricardo Albarran – Evaluation Team, PDQIB

Marion Carter – Evaluation Team, PDQIB

Mary McFarlane – PDQIB

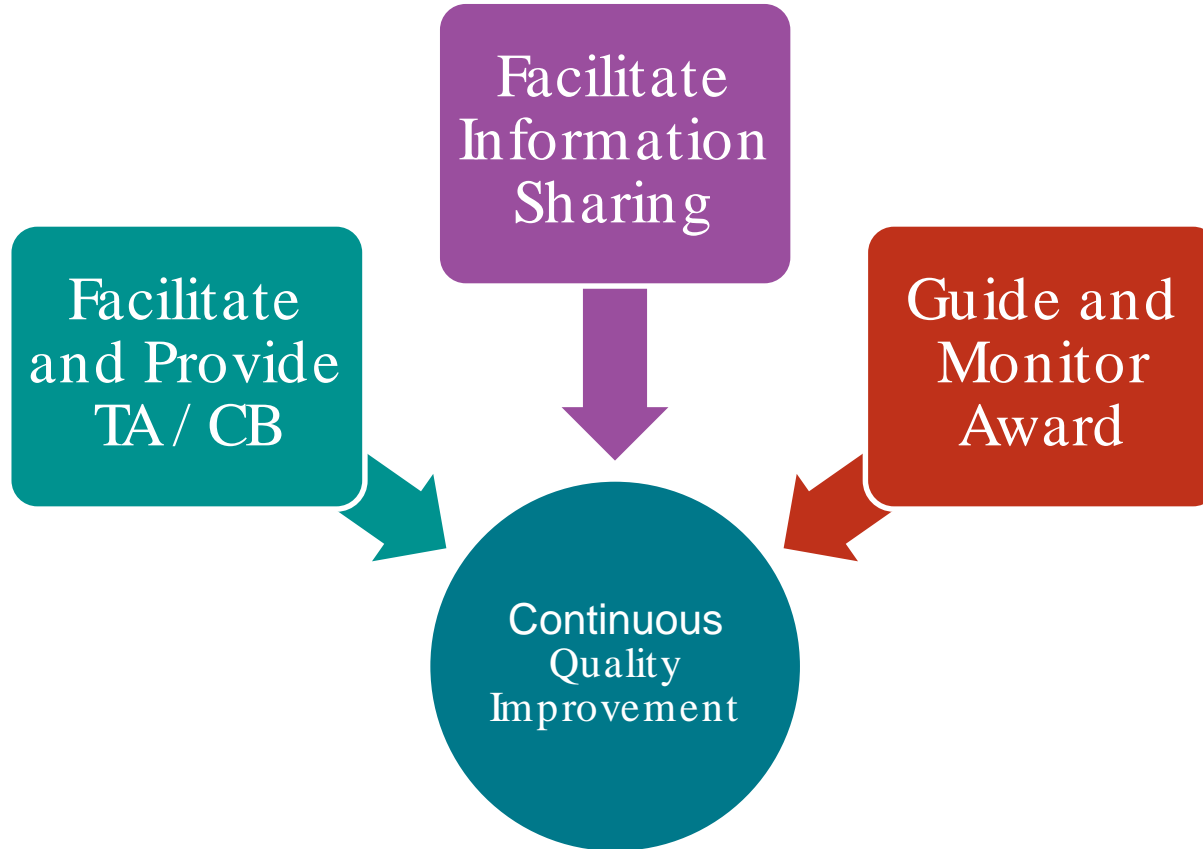
Kenya Taylor – Program Team, PDQIB

Lizzi Torrone – Surveillance and Data Management Branch

Today's Agenda

- STD PCHD program support
- STD AAPPS closeout information
- STD PCHD application review process
- Technical assistance planning
- Dates to remember
- Questions and Answers

Program Support Model



PS19-1901 Strengthening STD Prevention and Control for Health Departments (STD PCHD) 2019-2023



SURVEILLANCE

- Conduct chlamydia (CT) surveillance
- Conduct gonorrhea (GC) surveillance
- Conduct syphilis surveillance
- Conduct congenital syphilis (CS) surveillance
- Conduct surveillance of adverse outcomes of STDs



DISEASE INVESTIGATION AND INTERVENTION

- Respond to STD-related outbreaks
- Conduct health department disease investigation and intervention for pregnant women with syphilis and other reproductive-age women with syphilis
- Promote Expedited Partner Therapy (EPT) (where permissible) to partners of chlamydia and/or gonorrhea cases
- Conduct health department syphilis disease investigation and intervention for men with primary and secondary syphilis



PROMOTION OF CDC RECOMMENDATIONS

- Promote quality STD specialty care services
- Promote CDC-recommended treatment for gonorrhea and syphilis
- Promote CDC-recommended screening, diagnosis, and treatment of STDs among high priority populations



PROMOTION OF PREVENTION AND POLICY

- Promote STD prevention to the public
- Promote STD prevention and reporting to provider community
- Monitor STD-related policies and policy development



DATA USE FOR PROGRAM IMPROVEMENT

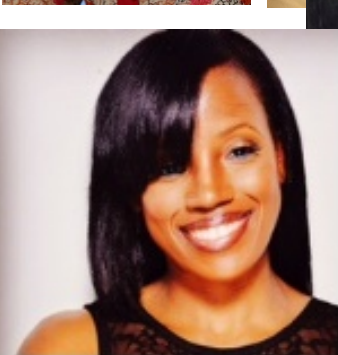
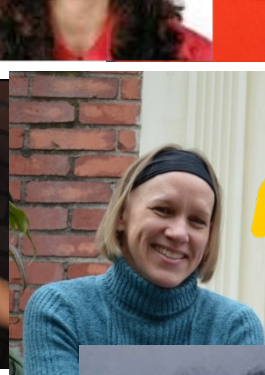
- Conduct epidemiologic analysis, translation, and dissemination
- Conduct data-driven planning, analysis, monitoring, and evaluation for program improvement

CROSS-CUTTING:

Promote STD-Related HIV Prevention

Develop, Maintain, and Leverage Partnerships

For more info: e-mail STD_PCHD@cdc.gov



Meet the Prevention Specialists in PDQIB



Tawanda Asamaowei



Britney Johnson



Nina Johnson



Cassandra Davis



Kenya Taylor



Bianca Perri



Collaboration



Evaluation Team



Shaunta
Wright



Brandy
Maddox



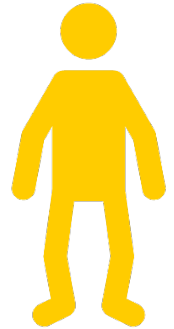
Emily Hays



Ricardo
Albarran



Marion Carter



Dayne Collins



Kristen Kreisel

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Emily Weston

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Sarah Kidd

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Jeremy Grey

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Alesia Harvey

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Darlene Davis

CS reporting
dwd1@cdc.gov

STD A APPS

Before we discuss STD PCHD

Closing out STD A APPS

Check GrantSolutions!

The Technical Review for Annual Performance Report (APR)

- Program team has reviewed all of the documents submitted in August 2018
 - ❖ 2017 Final progress report
 - ❖ 2018 Midyear progress report
- All technical reviews will be available in GrantSolutions by January 25, 2019.
- Responses to the technical review are not required
- Comments or questions about technical reviews can be addressed to the Prevention Specialist or STD_PCHD@cdc.gov

STD AAPPS 14-1402 Closeout

■ Submission Method

- ❖ GrantSolutions.gov as a Grant Note
- ❖ Grant Note Category Type: Closeout

■ Submission Deadline is March 30, 2019

■ Questions or Concerns

- ❖ Programmatic documents: Email your assigned Prevention Specialist or STD_PCHD@cdc.gov
- ❖ Administrative documents: Email your assigned Grants Management Specialist Portia Brewer yfa2@cdc.gov

STD AAPPS 14-1402 Closeout continued

■ Required documents

- ✓ Final Federal Financial Report (FFR)
- ✓ Invention Statement
- ✓ Equipment Inventory Form
- ✓ Final Performance Report
- ✓ STD AAPPS Supplemental Funding report
- ✓ Reporting of Publications (citations for journal articles and major conference presentations)
- ✓ STD AAPPS 2014-2018 Project Period Report
- ✓ 2018 AAPPS Work Plan Annual Progress Update

If Applicable:

- ✓ Congenital Syphilis Progress Report
- ✓ GISP Final Progress Report
- ✓ Evaluation Final Report Summary Narrative

STD PCHD

STD PCHD Application Technical Reviews

Your REVISIONS due February 4

- Technical reviews conducted by Division of STD Prevention staff New Approach for Application Reviews
 - ❖ Each application received an in-depth review by
 - ✓ Prevention Specialist (*comprehensive review*)
 - ✓ Surveillance Team (*reviewed work plan Strategy Area I*)
 - ✓ Evaluation Team (*reviewed evaluation components*)
 - ✓ PDQIB Branch Chief (*final review*)
- STD PCHD Kickoff calls for each site with their prevention specialist or primary reviewers
- Revisions due February 4, 2019 – discuss how to upload your revisions with your Prevention Specialist

Revisions due on February 4

- You have received from us:
 - ❖ Technical Review
 - ❖ Recommendations Summary
 - ❖ “Unlocked” Work Plans for editing
- What’s required?
 - ❖ Revised Work Plans
 - ❖ Revised Budgets (if applicable)
 - ❖ Cover letter
 - ❖ Narrative Response: Responses to the Recommendations Summary
- Ask your prevention specialist how to submit your response in GrantSolutions

Technical Review Findings

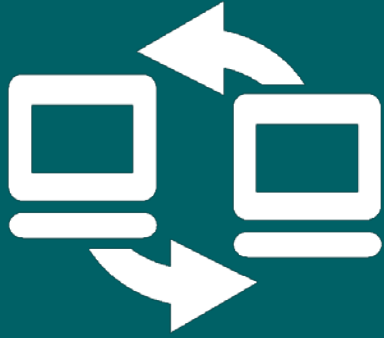
- In the Five-Year Work Plan, you told us, on a scale of 1 (low) to 5 (high):
 - ❖ How important is the strategy?
 - ❖ How strong is your program in this strategy?
- Strategies that were very important, but where programs felt less strong
 - ❖ Conduct data-driven planning, analysis, monitoring and evaluation for program improvement
 - ❖ Respond to STD-related outbreaks
 - ❖ Conduct congenital syphilis surveillance
 - ❖ Promote STD prevention and reporting to provider community
 - ❖ Promote STD prevention to the public

Technical Assistance Planning

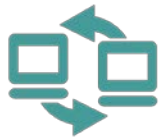
- **Priority strategies as noted by review of the proposals**
 - ❖ Enhanced surveillance for gonorrhea
 - ❖ Using program and epi data in decision-making
 - ❖ Outbreak response
 - ❖ Congenital syphilis
- **Goal for 2019: provide technical assistance on priority strategies**
 - ❖ Meet the need for effective and timely technical assistance within the time constraints of busy programs
 - ❖ Collaborating with partners to provide technical assistance that will best serve programs
 - ❖ Affinity Groups and other peer-to-peer sharing

Types of Technical Assistance



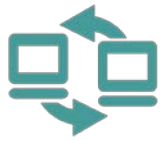


Strategy-specific Technical Assistance Plans: Surveillance Strategies



Surveillance-related resources

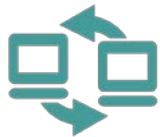
- **STD Surveillance Report**
 - ❖ <https://www.cdc.gov/std/stats/default.htm>
- **STD Surveillance Coordinator's quarterly calls**
 - ❖ Next call: Monday, January 28th 1 pm EST
 - ❖ Contact Ashley Vineyard (avineyard@cste.org) to be added to list
- **NCSD User Groups (Maven, PRISM, NBS)**
 - ❖ Contact Marvin Fleming (mqf6@cdc.gov) to be added
- **CSTE STD Surveillance Capacity Framework**
 - ❖ Coming soon!



1. Conduct chlamydia (CT) surveillance
- 2a. Conduct gonorrhea (GC) surveillance
- 3a. Conduct syphilis surveillance

*Collect, manage, analyze, interpret and disseminate data on identified cases of CT/GC/syphilis (all stages) ensuring timely capture of **core epidemiologic variables***

Core variables	CT	GC	Syphilis (all stages)
Age	✓	✓	✓
Sex	✓	✓	✓
County	✓	✓	✓
Diagnosing facility type	✓	✓	✓
Specimen collection date	✓	✓	✓
Anatomic site of infection	✓	✓	



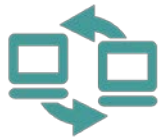
1. Conduct chlamydia (CT) surveillance
- 2a. Conduct gonorrhea (GC) surveillance
- 3a. Conduct syphilis surveillance

Suggestions

- Focus on processes to improve data quality and timeliness
- Begin discussions about transition to the STD Message Mapping Guide (MMG)

TA Resources

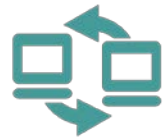
- STD Data Management & Information Technology website
Updates coming soon on LGV reporting and coding of the case status variable
<https://www.cdc.gov/std/program/data-mgmt.htm>
- NNDSS modernization Initiative (NMI) technical assistance
<https://www.cdc.gov/nmi/ta-trc/index.html>



2b. Conduct enhanced GC surveillance

*Conduct provider follow-up and, if needed, brief patient interviews of **a random sample of GC cases** from **a well-defined high morbidity area** or the project area as a whole. Ensure timely and quality capture of core epidemiological variables:*

- Age
- Sex
- County
- Diagnosing facility type
- Specimen collection date
- All anatomic site(s) of infection
- Race/ethnicity
- Gender identity/sexual orientation
- Sex of sex partner(s)
- Clinical Symptoms and signs
- Pregnancy status
- HIV status
- Previous history of GC
- PID
- Disseminated gonococcal infection
- Treatment provided
- Date of treatment
- Co-infection with other STDs
- History of substance abuse
- Partner treatment (e.g., EPT provision)



2b. Conduct enhanced GC surveillance

Suggestion

Take an incremental approach based on level of experience with enhanced surveillance. For example, for a jurisdiction with no experience:

Year 1

- Identify well, defined geographic area; gain local jurisdiction support
- Develop and validate methods for taking a random sample of all cases in that area

Year 2

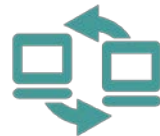
- Finalize data collection protocols, hire interviewers
- Modify (if needed) surveillance information system to store and export enhanced data
- Pilot interviews and methodology for weighting

Year 3

- Conduct interviews
- Conduct non-response analyses to monitor implementation
- Analyze data using weights to generate representative estimates

Years 4 & 5

- Ongoing implementation & quality improvement activities



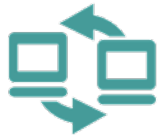
2b. Conduct enhanced GC surveillance

TA Resources

- PCHD Technical assistance (TA) note on enhanced surveillance
<https://www.cdc.gov/std/funding/docs/STD-PCHD-TA-Notes-2b-Enhanced-GC-Surveillance-Methodology.pdf>
- STD Surveillance Network (SSuN) protocol
<https://www.cdc.gov/std/ssun/default.htm>
- Webinar on random sample methodology and best practices (early March)
- CSTE Enhanced Gonorrhea Surveillance Tool Kit (fall 2019)
- Investigating options for peer-to-peer TA

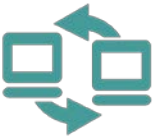
3b. Conduct P&S syphilis surveillance

*Conduct provider follow-up and, if needed, brief patient interviews of **all cases of P&S syphilis**. Ensure timely and quality capture of **core epidemiologic variables***



Core variables	Syphilis (all stages)	All P&S syphilis
Age	✓	✓
Sex	✓	✓
County	✓	✓
Diagnosing facility type	✓	✓
Specimen collection date	✓	✓
Race/ethnicity		✓
Gender identity		✓
Sexual orientation		✓
Sex of sex partners		✓
Pregnancy status		✓
Clinical signs/symptoms		✓
HIV status		✓
Substance use		✓
Treatment received		✓
Date of treatment		✓
History of syphilis		✓

3b. Conduct P&S syphilis surveillance



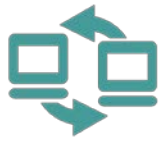
Suggestions

- Focus on improving percent complete of variables with lowest percent complete
- Match with eHARS to improve completion of HIV status

TA Resources

- Recommendations for syphilis surveillance in the U.S.
<https://www.cdc.gov/std/syphsurvreco.pdf>
- CSTE webinar on syphilis staging
<https://www.cste.org/page/WebinarLibrary>
(CSTE/CDC Syphilis Webinar 1)
- NCSD User Groups
Email Marvin Fleming to be added (mqf6@cdc.gov)

4. Conduct congenital syphilis (CS) surveillance



All recipients

To better understand CS epidemiology, conduct provider and mother follow-up and review medical records of all reported CS cases

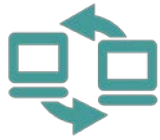
Suggestions

- Use correct CS case report form
- Ensure complete treatment & testing information on case report

TA Resources

- CS case report form & reporting instructions
<https://www.cdc.gov/std/program/ConSyphInstructions2013.pdf>
<https://www.cdc.gov/std/program/congenital-syphilis-form-2013.pdf>
More guidance coming soon via CSTE CS workgroup
- Contact Sarah Kidd (hgk9@cdc.gov) with CS reporting questions

4. Conduct congenital syphilis (CS) surveillance



Recipients with ≥ 10 CS cases

Improve methods to match syphilis surveillance data and vital statistics birth and mortality data

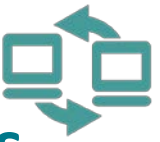
Strengthen CS morbidity and mortality case review boards

Suggestions

- Start with retrospective matches
- Consider semi-annual matching

TA Resources

- Protocols, tools, lessons learned, and best practices from CS supplement areas
- List of commonly-requested Vital Stats variables
- FIMR-HIV resources from CityMatCH
- CS Special Interest Group: to be continued



5. Conduct surveillance of adverse outcomes of STDs

Conduct active surveillance of adverse outcomes of adult syphilis including neurosyphilis and otic and ocular syphilis

Suggestions

- Consider how to collect, store, and report these clinical manifestation data elements

TA Resources

- Syphilis case definitions, including definitions of clinical manifestations
<https://www.cdc.gov/std/program/data-mgmt.htm>
- CSTE webinar
<https://www.cste.org/page/WebinarLibrary>
(CSTE/CDC Syphilis Webinar 2)

Wow. That was a lot of information!

- Don't worry if you missed something or couldn't copy down a link, slides will be available
- We are here to help!
 - ❖ Start with your prevention specialist, but DSTDP surveillance and data management staff are available as needed
 - ❖ Suggest other surveillance-related TA resources that would be useful

Strategy-specific Technical Assistance Plans: Outbreak response

6. Respond to STD-related outbreaks



Review STD surveillance data at regular intervals to identify outbreaks

Develop and maintain an outbreak capacity plan

TA Resources

- CSTE Syphilis Outbreak detection guidance & webinar
<https://www.cdc.gov/std/program/data-mgmt.htm>
<https://www.cste.org/page/WebinarLibrary> (Overview of Syphilis Outbreak Detection Guidance)
- DSTDP STD Outbreak Response and Coordination Effort (SOURCE)
If you suspect an outbreak: contact your prevention specialist who will connect with SOURCE
- Template HANs (in preparation)
- Table top exercise focusing on resistant GC (in preparation)
- Best practices for responses (in preparation)

Strategy Specific Technical Assistance Plans: Data Use for Program Improvement



Introducing . . . the Evaluation and Program Improvement Capacity Project

- New project with the National Network of Public Health Institute and its affiliate, the Rocky Mountain Public Health Training Center
- For any STD PCHD project area staff that want to strengthen skills and capacity in evaluation and program improvement
- Supports implementation of Strategy Area V, Strategy 17
 - *Conduct data-driven planning, analysis, monitoring and evaluation for program improvement*

Evaluation and Program Improvement Capacity Building Project: Overview



- ✓ Prepared to support up to 30 project areas
- ✓ Flexible participation and support model
- ✓ No cost to participate, except for time
- ✓ No prerequisites, except interest and intent to commit
- ✓ Run throughout 2019, starting in March



Interested? How to find out more

- Jan 24: Informational webinar by NNPHI (optional)
 - Overview and registration information were sent out earlier this week through STD_PCHD email
- Feb 8: Registration to join, due to NNPHI
 - Brief & online
- Mar 1: Engage participants with coaches



Update on Evaluation and Performance Measurement for STD PCHD

Refresher on NOFO requirements

“Recipients will be required to submit a **more detailed Evaluation and Performance Measurement plan**, including a **Data Management Plan**, within the first 6 months of award” (p.26)

- What are these?
- What will be required?
- When?
- What next?

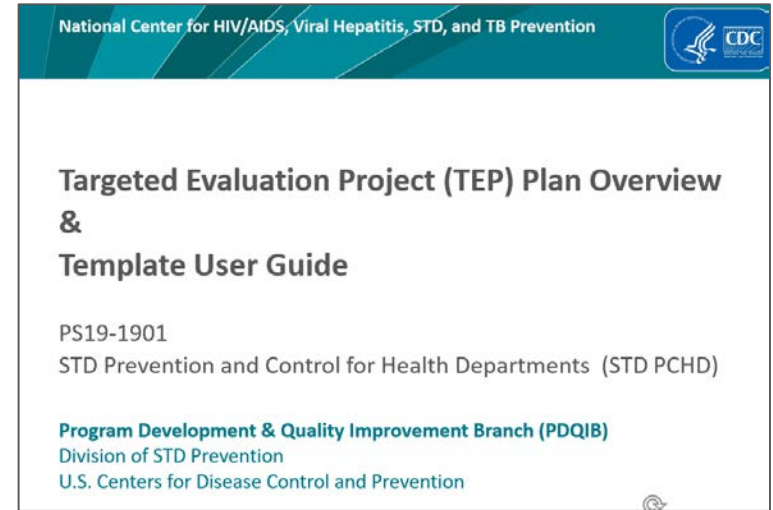
Evaluation and Performance Measurement Plan

- For STD PCHD, we are only requesting a Targeted Evaluation Project (TEP) Plan
- Performance measures are still under development, so we cannot ask for a plan around those at this time

For STD PCHD Year 1 ~~Evaluation and Performance Measurement Plan~~

Targeted Evaluation Project or TEP: What is this?

- A small-scale, feasible evaluation project that helps you better understand or improve your program
- Topic, scope, methods, timeframe will vary across project areas
- Planning tool greatly simplified compared to STD AAPPS
- The planning tool, with guidance, will be issued in next few weeks



More guidance:
Coming soon to an inbox near you!

Targeted Evaluation Project or TEP: Next steps?

- Each project area will have its own TEP TA provider
- TEP TA providers will reach out in February to start to help you understand the TEP requirement and plan a good TEP
- Complete, final TEP plan due by June 30, 2019



CDC Evaluation Framework

We'll help walk you through all this

Refresher on NOFO requirements

“Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan, including a **Data Management Plan**, within the first 6 months of award” (p.26)

- What are these?
- What will be required?
- When?
- What next?

Data Management Plan or DMP: What to expect?

- A plan that helps ensure that all data collected under a NOFO are accessible and stored appropriately
- Complements PCSI confidentiality and security guidelines
- Must be more than a checklist or statement of assurance
- Sample template, with instructions, will be issued in a few weeks
- Also due by June 30, 2019

TEPs and DMPs: Recap

February 2019

- Guidance issued for both

Feb-May 2019

- Consult your local colleagues and your DSTDP TEP TA provider on TEP
- Consult your local data stewards and your DSTDP prevention specialist on DMP

June 2019

- Submit both, together, to DSTDP = “Evaluation and Performance Measurement Plan” required within 6 months of award

Bottom line:

- ✓ Don't worry about these for now
- ✓ Stay tuned for more
- ✓ There is time to both understand and work on them



Update on STD PCHD Performance Measures Development

Refresher from the NOFO

“CDC expects recipients to send data to CDC on a regular basis, so that CDC can track progress towards achieving certain key outcomes of the NOFO. **CDC will finalize these measures, their specific definitions, benchmarks, submission frequency, and submission templates in consultation with recipients within 6 months of award.**” (p.22)

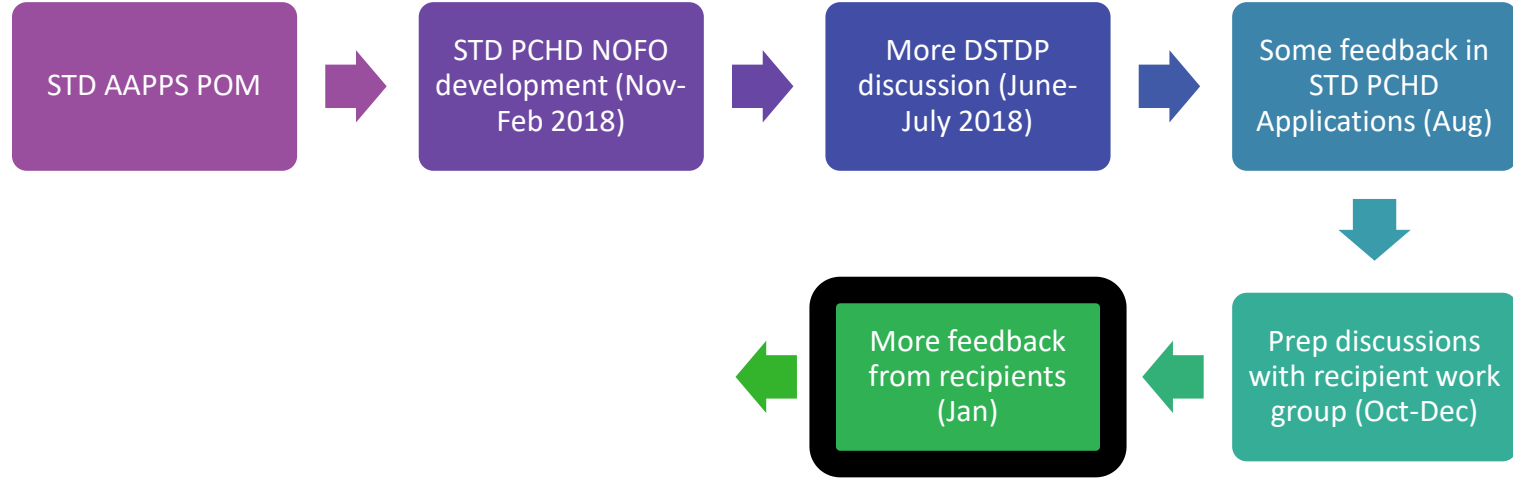
Aim for STD PCHD Performance Measures

A common set of measures that is:

- Relatively small in number
- Within the control of each project area to obtain and calculate
- Reflective of more of the work that STD PCHD funds in your area
- Useful for you and us to see in comparative perspective and over time



Performance Measures: Where are we?

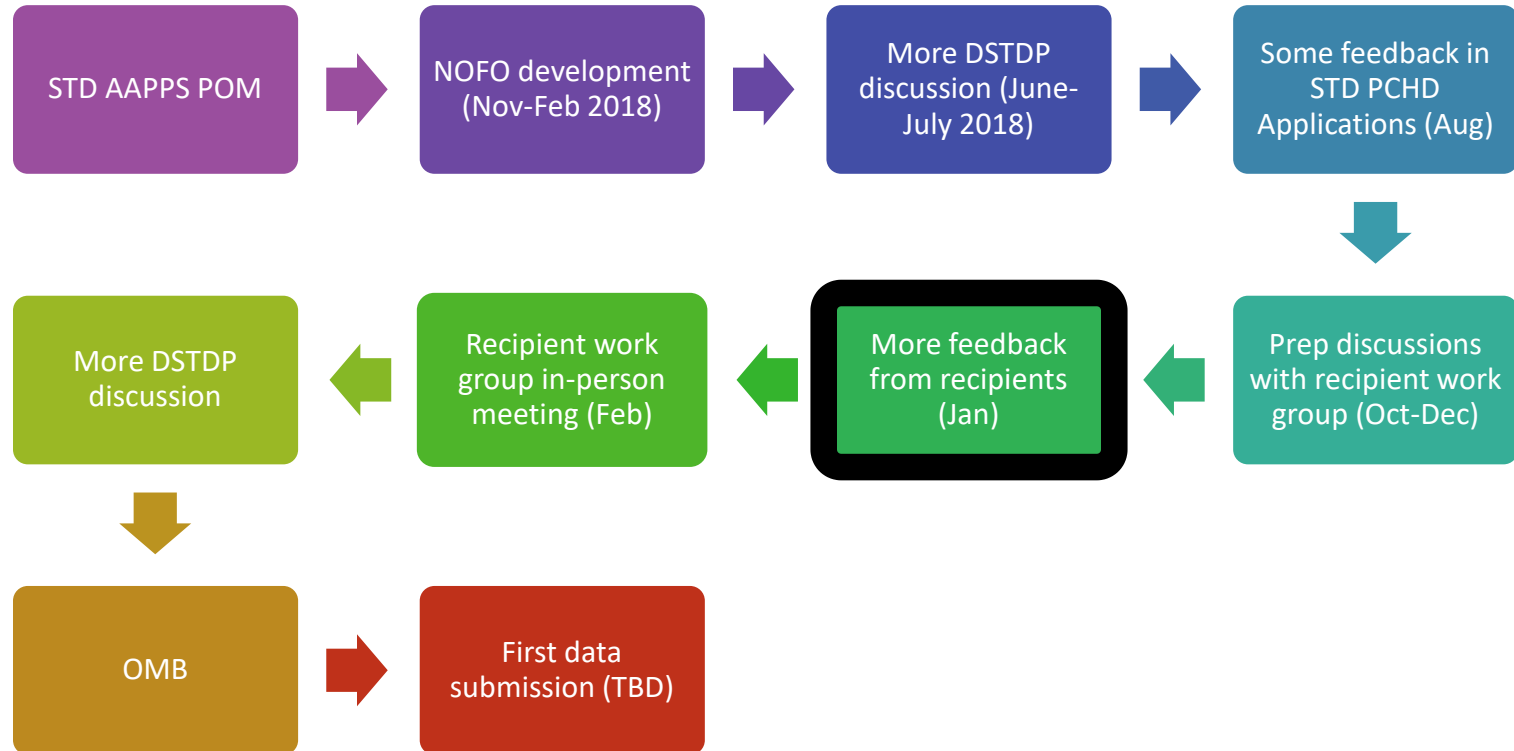


Another feedback opportunity

- Current list of measures ≠ List provided in NOFO
- Optional and anonymous feedback on feasibility, utility, other suggestions or concerns
- Survey link will be sent out next week to all project areas
- Results of feedback will be included in deliberations of recipient work group meeting (mid-Feb)

Performance Measures Work Group reps are from:	
California	Florida
New York City	Georgia
Pennsylvania	Tennessee
Puerto Rico	Michigan
Vermont	New Mexico
Wyoming	Kansas

Performance Measures: Where are we?



Resources & Important STD PCHD Dates

Resources

- Work Plan templates and other helpful documents for communicating with DSTDP
- Internal protocols and plans for supporting the programs
- Plans for creating a web space for sharing program information among all recipients
- Commitment to providing clear and helpful reports and feedback to programs
- Plans to collaborate externally to provide optimal support to programs

Deadlines for STD PCHD 19-1901

Requirement/Deliverable	Submission Method	Deadline
STD PCHD Technical Review Responses	Grantsolutions.gov as a Grant Note, Category TR Response	February 4, 2019
Evaluation & Performance Measurement Plan, & Data Management Plan	Grantsolutions.gov as a grant note	June 30, 2019
Year 2 Continuation Application	Grants.gov	August 30, 2019
2018 Interim Progress Report	Grantsolutions.gov as a grant note	August 30, 2019
Prior Approvals (e.g. redirections)	Grantsolutions.gov as an amendment	August 30, 2019
Annual FFR	Grantsolutions.gov	March 31, 2020
Annual Performance Report & Data on Performance Measures	Grantsolutions.gov as a grant note	March 31, 2020

Program Contacts

- Jennifer Fuld jfuld@cdc.gov (404) 718-5983
- Marion Carter acq0@cdc.gov (404) 639-8035
- Mary McFarlane xzm3@cdc.gov (404) 639-8309
- Kenya Taylor kft8@cdc.gov (404) 718-8815
- Britney Johnson mwq4@cdc.gov (404) 718-5604
- Nina Johnson wvi3@cdc.gov (770) 488-6455
- Cassandra Davis vts4@cdc.gov (404) 498-3099
- Tawanda Asamaowe lhy0@cdc.gov (404) 718-6389
- Bianca Perri ftn5@cdc.gov (404) 718-7678
- Lizzi Torrone igf0@cdc.gov (404) 639-8948
- STD PCHD Questions STD_PCHD@cdc.gov

PS19-1901 Strengthening STD Prevention and Control for Health Departments (STD PCHD) 2019-2023



SURVEILLANCE

- Conduct chlamydia (CT) surveillance
- Conduct gonorrhea (GC) surveillance
- Conduct syphilis surveillance
- Conduct congenital syphilis (CS) surveillance
- Conduct surveillance of adverse outcomes of STDs



DISEASE INVESTIGATION AND INTERVENTION

- Respond to STD-related outbreaks
- Conduct health department disease investigation and intervention for pregnant women with syphilis and other reproductive-age women with syphilis
- Promote Expedited Partner Therapy (EPT) (where permissible) to partners of chlamydia and/or gonorrhea cases
- Conduct health department syphilis disease investigation and intervention for men with primary and secondary syphilis



PROMOTION OF CDC RECOMMENDATIONS

- Promote quality STD specialty care services
- Promote CDC-recommended treatment for gonorrhea and syphilis
- Promote CDC-recommended screening, diagnosis, and treatment of STDs among high priority populations



PROMOTION OF PREVENTION AND POLICY

- Promote STD prevention to the public
- Promote STD prevention and reporting to provider community
- Monitor STD-related policies and policy development



DATA USE FOR PROGRAM IMPROVEMENT

- Conduct epidemiologic analysis, translation, and dissemination
- Conduct data-driven planning, analysis, monitoring, and evaluation for program improvement

CROSS-CUTTING:

Promote STD-Related HIV Prevention

Develop, Maintain, and Leverage Partnerships

For more info: e-mail STD_PCHD@cdc.gov

Peer Navigation (CHW)

Peer Navigators (Community Health Workers) are often HIV-positive, medication adherent role models, living with a shared experience as well as a shared community membership with the populations they work with.

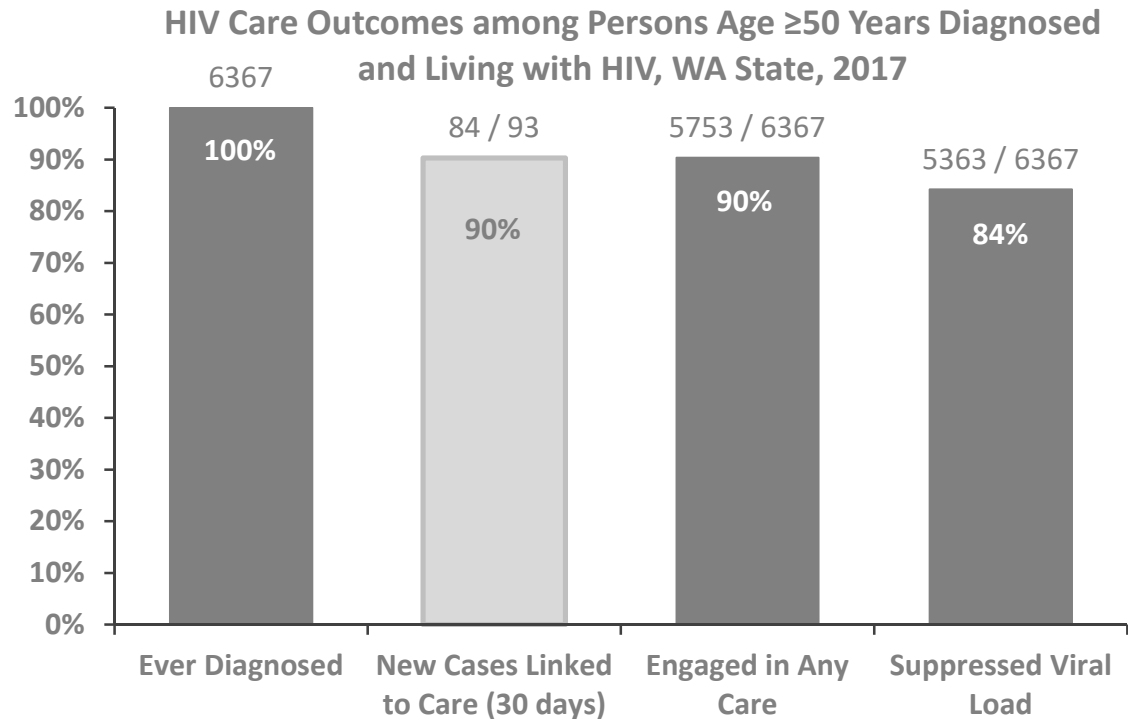
Program Update:

1. DOH has funded 9 peer navigators in 8 agencies!
2. DOH has partnered with DOC to fund 2 peers that will work with justice-involved clients!
3. DOH is providing additional technical assistance for Part A programs already in place (i.e. Lifelong's HART program and BABES)
4. CAP is hiring their 2nd peer for Cowlitz County!
5. Several peers were able to attend either USCA or HRSA RW Conference

HIV Over 50

- Persons age ≥ 50 years account for 49% of all persons living with HIV in Washington
- Persons age ≥ 50 years account for more than 20% of all new HIV diagnoses in Washington

What's working...



What we're concerned about...

Mental Health:

- Social isolation
- AIDS Survivor Syndrome
- Loss of Purpose

Physical Health:

- Pulmonary
- Cardio
- Metabolic
- Renal
- Multi-morbidities

Sexual Health

Are we addressing these issues in a substantive and inclusive manner?

What we're doing...

Community Listening Sessions

- First one was held in Spokane, WA (Oct, 2018)
- More sessions will be planned monthly beginning in February and ending in June.

Formation of Special Emphasis Workgroup

- Consisting of community partners and providers who currently work with high numbers of 50+ individuals (including HIV specialists, gerontologists, and community liaison).

Creation of email for communication

- HIVover50@doh.wa.gov



Contact:

Chris Wukasz

Peer Navigation and 50+ Community Engagement Coordinator

chris.wukasz@doh.wa.gov



DOH MICROGRANT UPDATES

January 17, 2019

MICROGRANT HISTORY

- Funding allocated through the legislature to support End AIDS Washington priorities starting in 2017-18 state fiscal year.
 - **Community Engagement:** 120K allocated per year during biennium. Each funded HIV Community Service agency eligible for up to \$6250 per year.
 - **Stigma Reduction:** 20K allocated per year. Could be divided in any way between agencies applying for funds to support a stigma project.
- Additional microgrant application period for October 2018-June 2019 included funding for Drug User Health projects at SSPs.
- Bi-annual narrative reporting structure to update DOH on progress made with allocated funds.
- Future funding contingent on legislative decisions.

MICROGRANT FUNDING 2018



Community Engagement

- 70K allocated for 2018 calendar year
 - 30K 2017-18 *fiscal year*
 - 40K 2018-2019 *fiscal year*
- Seven agencies applied and received funds
 - 2 LHJS
 - 5 CBOs



Stigma Reduction

- 38K allocated for 2018 calendar year
- Seven agencies/ collaborations applied and received funds
 - 4CBOs
 - 2 CFAR
 - 1 Collaboration

MICROGRANT FUNDING

OCT 2018-JUNE 2019

- 1 Community Engagement**
75K allocated
between 12
agencies
7 CBOs, 5 LHJs
- 2 Stigma Reduction**
52K allocated
between 7
agencies
5 CBOs, 2 LHJs
- 3 Drug User Health**
167K
allocated
between 9
agencies
2 CBOs, 7 LHJs
One time
funding

COMMUNITY ENGAGEMENT PROJECT EXAMPLES

1

Lifelong

King County LGBTQ Youth Leadership Conference:

One day intensive training for up-and-coming LGBTQ youth (ages 16-24) leaders. Enhance engagement in Lifelongs LGBTQ sexual health youth programming.

2

PCAF

Integrated CAB Retreat:

Leadership Development Retreat for CAB composed of PLWH & PAHR. Focus on developing skills for CAB members to fully engage in CAB activities and to provide leadership in community engagement activities.

3

Kitsap HD

Community Health Engagement Series:

Series of events to provide older, long-term PLWH social, health, educational opportunities to build capacity within the community. Coordinated by Kitsap's PLWH Peer Navigator.

STIGMA REDUCTION PROJECT EXAMPLES

1

CBO

The Stigma Project

explores the dynamics of external, internal, community, and structural stigma while concurrently examining how these dynamics are experienced by the different communities Areas of focus

U=U, Women and Gender, and Long-Term Survivors & Aging.

2

LHJ

PLWH advisory board

(HIV AIDS Advisory Board/ HAAB) and HD will collaboratively conduct a U=U outreach campaign in E. Washington. U=U educational materials and distributing U=U branded wearable swag- to forge greater visibility of the message and individual/group support for it.

3

CFAR

Fiscal support for

Trans woman to attend and regularly participate in the Center for AIDS Research Community Action Board (CFAR CAB); its Stigma Workgroup (and appropriate ad hoc committees—to include the Qualitative Data Review Committee or Literature Review Committee).

DRUG USER HEALTH PROJECT EXAMPLES



CBO – Rural Expansion

Program will purchase supplies to Increase the distribution of safer injection and safer sex supplies to isolated and hard to reach pockets of PWUD in Pierce County using vehicle-based distribution. Additionally, HIV and HCV testing will be offered on an outreach basis.



LHJ – Syringe Disposal

Program will procure and place syringe disposal kiosks for areas impacted by improper disposal of syringes. Develop a best practices document detailing how to work with community based agencies in order to properly dispose of used syringes, which can be shared throughout the state.

Q&A / DOH FEEDBACK

- If funding is available for next biennium, what feedback do you have for DOH staff?



Measles Update

#1

January 18, 2019



Clark County is currently responding to a measles outbreak. The Washington State Department of Health is supporting our local health partner in our shared mission of reducing the spread and length of the outbreak. In addition to the dozens of staff dedicated to this event, we have deployed a team of epidemiologists to Clark County to assist with case and contact investigation, and database development

This outbreak is expanding quickly. DOH is coordinating with Oregon, Multnomah County, tribal partners, local health jurisdictions, federal partners, and vaccine distributors.

What your constituents need to know

- Measles is extremely contagious, and can be serious, especially for young children.
- The most effective way to prevent measles is by being fully immunized.
- People who suspect they have been exposed and have symptoms of measles, should call their health care provider **prior** to visiting the medical office to make a plan that avoids exposing others in the waiting room.

Symptoms

- Early symptoms seem similar to a bad cold.
- High fever, runny nose, and cough, followed by a rash that lasts 5 to 6 days.
- Possible red, watery eyes that are sensitive to light and be very tired.

More resources

- Current case count: <https://www.clark.wa.gov/public-health/measles-investigation>
- Measles in Washington <https://doh.wa.gov/measles>.
- Check immunization records online: <https://wa.myir.net/>
- Measles information for travelers: <https://www.cdc.gov/measles/travelers.html>
- CDC information on measles <https://www.cdc.gov/vaccines/vpd/mmr/public/index.html>
- Information on who should NOT be vaccinated <https://www.cdc.gov/>

John Wiesman DrPH, MPH

Secretary of Health | 360-236-4030

1/16/2019

<p>To cancel orders, please contact McKesson:</p> <p>CDCCustomerService@McKesson.com</p>	<p>REMINDER: Based on the information in this table, ExIS awardees may need to update the list of NDCs in their ExIS (e.g., by manual entry into their ExIS or uploading the latest VTrckS federal vaccines list to their ExIS).</p>
<p>For vaccine inventory questions, please email:</p> <p>vaccinedistributionc@cdc.gov</p>	<p>Contact the Vaccine Order Management Contact Center if you encounter problems with this activity: 1-877-878-6247 or vaccineordermgmt@cdc.gov.</p>

Rows with no color signify a product with a depleted inventory or an inventory issue and alert you that action may need to be taken on your part.

Note:

58160-0812-11 (PEDIATRIC) GSK Kinrix	
58160-0812-52 (PEDIATRIC) GSK Kinrix	
58160-0815-52 (PEDIATRIC & ADULT) GSK Twinrix	
58160-0818-11 (PEDIATRIC) GSK Hiberix	
58160-0823-11 Zoster (ADULT) GSK Shingrix	
58160-0819-12 Zoster (ADULT) GSK Shingrix	
58160-0820-52 Hep B (PEDIATRIC) GSK Engerix B	
58160-0825-11 (PEDIATRIC) GSK Havrix	
58160-0826-52 Hep A (ADULT) GSK Havrix	
00006-4841-41 Hep A (ADULT) Merck Vagta	
00006-4096-02 Hep A (ADULT) Merck Vagta	
00006-4981-00 Hep B (PEDIATRIC) Merck Recombivax HB	
00006-4093-02 Hep B (PEDIATRIC) Merck Recombivax HB	
00006-4094-02 Hep B (ADULT) Merck Recombivax HB	
00006-4995-41 Hep B (ADULT) Merck Recombivax HB	

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Introduction

Washington's governmental public health system (**governmental public health system**) has a critical and unique public safety role that is focused on protecting and improving the health of Washington's families and communities. According to state law,¹ protecting the public's health is a fundamental responsibility of Washington State.

The **governmental public health system**, is made up of 37 governmental public health authorities, including the Washington State Department of Health (DOH), Washington State Board of Health (SBOH), 35 local health jurisdictions (LHJs) and Tribal Nations. Washington's overall public health system is much larger, and also includes other government organizations, and partners, such as health care providers and community-based organizations (CBOs).

Like public safety (fire, police), public utilities (power, water) and other public infrastructure (roads, sewers) there is a foundational level of public health services that must exist everywhere for services to work anywhere. This foundation, called the **Foundational Public Health Services (FPHS)** is a subset of all public health services. **FPHS** are a limited statewide set of core public health services and include **foundational capabilities and programs** that (1) must be available to all people in Washington, and (2) meet one or more of the following criteria:

- Services for which the **governmental public health system** is the only or primary provider of the service, statewide.
- Population-based services (versus individual services) that are focused on prevention.
- Services that are mandated by federal or state laws.

FPHS provide a strong foundation from which the state and local communities can deliver **Additional Important Services (AIS)**. These are services that are critical locally and do not necessarily need to be provided by the **governmental public health system** statewide because **AIS** are a shared responsibility of local, state and federal public health and other partners. **AIS** often respond to or are local community priorities. They can also be driven by state initiatives to address disparities across the state.

The differentiation between **FPHS** and **AIS** is not a value judgement, nor is one set of services more important than the other. **FPHS** and **AIS** are both essential to support healthy and economically vital communities across Washington.

This document provides **functional definitions** for **FPHS**.

FPHS Framework

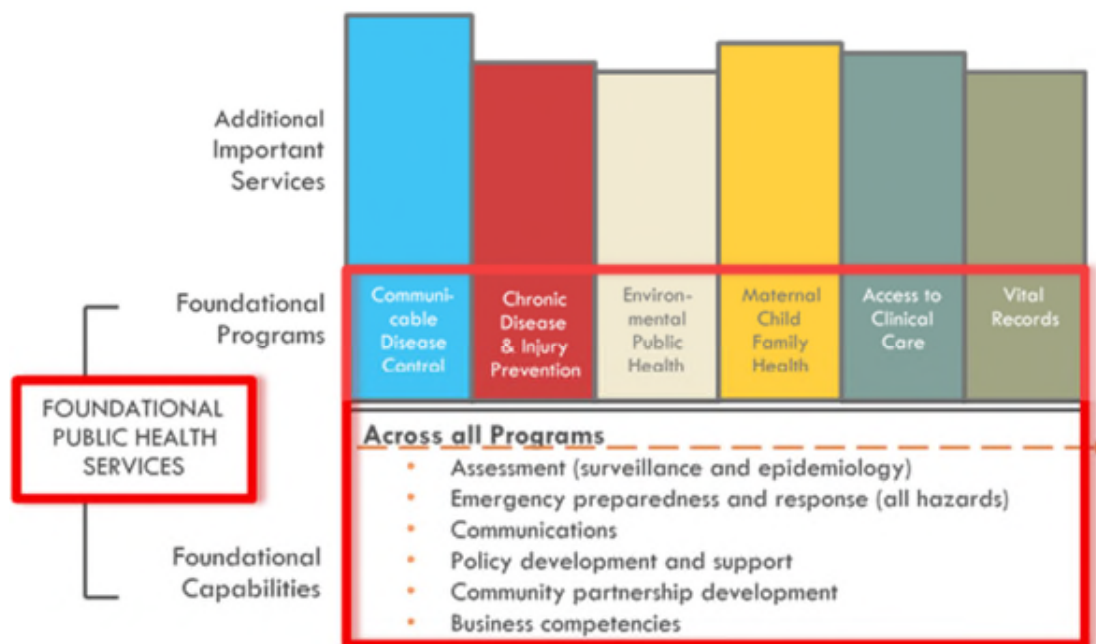
Local and State public health leaders in Washington have been working to develop Washington's **FPHS** framework since 2011. Their work has been guided by the following assumptions:

¹ Revised Code of Washington (RCW) 43.70.512:

1. The **FPHS** framework is based on the role of the **governmental public health system**; it does not include public health services provided by other providers within the overall public health system.
2. The **FPHS** framework defines the services that residents need to have access to or have provided for them everywhere statewide and should be “agnostic” about which governmental public health authority provides them.

Washington’s **FPHS** Framework is shown in Exhibit 1.

Exhibit 1: Washington’s Foundational Public Health Service Framework



National FPHS Framework

In 2009, the Institute of Medicine (IOM) formed a committee to consider three topics related to population health: data and measurement, law and policy, and funding. Their work culminated in a report, *For the Public’s Health: Investing in a Healthier Future* (2012), in which the IOM recommended that a minimum package of public health services be defined. In April 2013, the Public Health Leadership Forum, funded by the Robert Wood Johnson Foundation and facilitated by RESOLVE, developed the national FPHS framework to define this “minimum package of services.” The FPHS framework included foundational capabilities and programs that the group felt were needed everywhere for public health to work anywhere, and for which costs could be estimated. This national model is now stewarded by the Public Health National Center for Innovations (PHNCI) has been and continues to be adopted and localized by states across the nation, including Washington. More information on the national FPHS framework is available [here](http://phnci.org/uploads/resource-files/PHNCI-FPHS-Factsheet_FINAL-1.pdf).²

² PHNCI FPHS Fact Sheet: http://phnci.org/uploads/resource-files/PHNCI-FPHS-Factsheet_FINAL-1.pdf.

As shown in Exhibit 1, Washington’s Public Health Services Framework defines six **foundational capabilities** and six **foundational programs**:

Foundational capabilities are the crosscutting **capacity** and **expertise** needed to support public health programs.

- A. Assessment (Surveillance and Epidemiology)
- B. Emergency Preparedness (All Hazards)
- C. Communication
- D. Policy Development and Support
- E. Community Partnership Development
- F. Business Competencies

Foundational programs are the subset of services in each public health program area that are defined as foundational. In Exhibit 1 this is illustrated by the sections of each colored program column inside the red box.

- G. Prevention and Control of Communicable Disease and Other Notifiable Conditions
- H. Chronic Disease, Injury and Violence Prevention
- I. Environmental Public Health
- J. Maternal/Child/Family Health
- K. Access/Linkage with Medical, Oral and Behavioral Health Care Services
- L. Vital Records

Together, the **foundational capabilities** and **foundational programs** are the limited statewide set of core public health services that must exist everywhere for services to work anywhere.

The Washington **FPHS** framework was first defined by the **FPHS** Technical Workgroup in 2012, then revised by the 2014 **FPHS** Policy Workgroup, and was most recently published as FPHS Definitions V1.2 in March 2016.³ The original definitions simply included three to seven **elements** under each **foundational capability** and **program** which described the foundational work.

However, for the **governmental public health system** to successfully and consistently implement **FPHS**, more detail was needed in the definitions. In 2017, the **FPHS** Technical Workgroup oversaw the development of **functional definitions** that:

- Describe “what” **FPHS** provides for Washington’s communities, but not “how” the **governmental public health system** should provide it,
- Are agnostic to which governmental public health provider should provide it,

³ FPHS Definitions V1.2, March 2016: <https://www.doh.wa.gov/Portals/1/Documents/1200/FPHS-2016definitions.pdf>.

- Are reduced to discreet **activities** (define as few actions as possible per statement) and begin with a verb identifying the action to be taken and,
- Align with existing guidelines and regulations.

These **functional definitions** add detail by establishing **activities** under the **elements** for each **foundational capability and program**.

As part of the **functional definitions** development process, some revisions were made to **FPHS** Definitions V1.2, March 2016 and approved by both the **FPHS** Technical Workgroup and Steering Committee.

This edition of the definitions highlights the **governmental public health system's** role as community strategist with a focus on the foundational services of data, planning and working with partners to develop and implement prioritized plans, seek resources and advocate for high priority policy initiatives.

These definitions are published in this document, the *Foundational Public Health Services Functional Definitions Manual* and are considered Version 1.3.

Future Update Processes

It is expected that these definitions will continue to evolve alongside the public health practice. A process will be established for periodic updates to the **FPHS** definitions, as documented in this *Foundational Public Health Services Functional Definitions Manual*.

How to Use this Manual: Understanding and Implementing Functional Definitions

This document provides **functional definitions** for Washington’s **foundational capabilities and programs** meant to help governmental public health authorities operationalize this framework statewide across the public health system, and within their organizations. Each **foundational capability and program** definition includes:

- **12 Foundational Capabilities and Programs (6 Foundational Capabilities and 6 Foundational Programs).** Uppercase lettered A. to L.

Example: A. denotes the foundational capability “Assessment (Surveillance and Epidemiology).”

- **48 Elements.** Numbered and individually assigned to one **foundational capability or program**, such that they are represented as “[Foundational Capability Uppercase Letter].[Element Number].”

Example: A. 1. Denotes the first element of Assessment (Surveillance and Epidemiology), “Ability to collect sufficient statewide and community-level data to develop and maintain electronic information systems to guide public health planning and decision making at the state, regional and local level. Foundational data include (but are not limited to):

- Behavioral Risk Factor Surveillance System (BRFSS),
- Healthy Youth Survey (HYS), and
- Vital statistics.

Foundational information systems include:

- Washington Disease Reporting System (WDRS),
- Washington Electronic Lab Reporting System (WELRS), and
- Selected clinical data systems (e.g. Comprehensive Hospital Abstract Reporting System [CHARS] and Community Health Assessment Tool [CHAT])”

- **350 Activities.** Lowercase lettered and individually assigned to one Element, which are also individually assigned to one **foundational capability or program**, such that they are represented as “[Foundational Capability Uppercase Letter].[Element Number].[Activity Lowercase Letter]”

Example: A.1.a. denotes the first activity under the first element of Assessment (Surveillance and Epidemiology), “Assure access to public health informatics capability.”

It is important to remember that there is significant interplay among the **foundational capabilities and programs**, so governmental public health staff need to be familiar with the full definitions manual, and not simply the definitions specific to the work they do.

Hyperlinks are used throughout the manual to support navigation of the document, and particularly to connect key terms to their definitions in the glossary. To use a hyperlink, simply click the link. After using a hyperlink, you can press Alt + Left Arrow to return to where you were.

Washington Foundational Public Health Services Functional Summary Definitions

Version 1.3, November 2017

FOUNDATIONAL CAPABILITIES

A. Assessment (Surveillance and Epidemiology).

The functional definition of this foundational capability includes:

1. **Ability to** collect sufficient, statewide and community level data and develop and maintain electronic information systems to guide public health planning and decision making at the state, regional and local level. Foundational data include (but are not limited to):

- Behavioral Risk Factor Surveillance System (BRFSS),
- Healthy Youth Survey (HYS), and
- Vital statistics.

Foundational information systems include:

- Washington Disease Reporting System (WDRS),
- Washington Electronic Lab Reporting System (WELRS), and
- Selected clinical data systems (e.g. Comprehensive Hospital Abstract Reporting System [CHARS] and Community Health Assessment Tool [CHAT]).

2. **Ability to** access, analyze, use and interpret data, including:

- U.S. Census,
- Vital Statistics,
- Notifiable condition data,
- Selected clinical data sets including Comprehensive Hospital Abstract Reporting System (CHARS),
- Behavioral Risk Factor Surveillance System (BRFSS),
- Healthy Youth Survey (HYS),
- Basic community and environmental health indicators, and
- Financial data.

3. **Ability to** conduct a comprehensive community or statewide health assessment and identify health priorities arising from that assessment, including analysis of health disparities and the social determinants of health.

B. Emergency Preparedness (All Hazards).

The functional definition of this foundational capability includes:

1. **Ability to** develop emergency response plans for natural and man-made public health hazards; train public health staff for emergency response roles and routinely exercise response plans.
2. **Ability to** lead the Emergency Support Function 8 – Public Health & Medical and/or a public health response for the county, region, jurisdiction and state.
3. **Ability to** activate and mobilize public health personnel and response teams; request and deploy resources; coordinate with public sector, private sector and non-profit response partners and manage public health and medical emergencies utilizing the incident command system.
4. **Ability to** communicate with diverse communities across different media, with emphasis on populations that are disproportionately challenged during disasters, to promote resilience in advance of disasters and protect public health during and following disasters.

C. Communication.

The functional definition of this foundational capability includes:

1. **Ability to** engage and maintain ongoing relations with local and statewide media.
2. **Ability to** develop and implement a communication strategy, in accordance with **Public Health Accreditation Standards**, to increase visibility of public health issues. This includes the **ability to** provide information on health risks, healthy behaviors, and disease prevention in culturally and linguistically appropriate formats for the various communities served.

D. Policy Development and Support.

The functional definition of this foundational capability includes:

1. **Ability to** develop basic public health policy recommendations. These policies must be evidence-based, or, if innovative/promising, must include evaluation plans.
2. **Ability to** work with partners and policy makers to enact policies that are evidence-based (or are innovative or promising and include evaluation plans) and that address the social determinants of health and health equity.
3. **Ability to** utilize cost-benefit information to develop an efficient and cost-effective action plan to respond to the priorities identified in a community and/or statewide health assessment.

E. Community Partnership Development.

The functional definition of this foundational capability includes:

1. **Ability to** create and maintain relationships with diverse partners, including health-related national, statewide and community-based organizations; community groups or organizations representing populations experiencing health inequity; private businesses and health care organizations; Tribal Nations, and local, state and federal government agencies and leaders.
2. **Ability to** select and articulate governmental public health roles in programmatic and policy activities and coordinate with these partners.

F. Business Competencies.

The functional definition of this foundational capability includes:

1. Leadership Capabilities. **Ability to** lead internal and external stakeholders to consensus and action planning (adaptive leadership) and to serve as the public face of governmental public health in the community.
2. Accountability and Quality Assurance Capabilities. **Ability to** uphold business standards and accountability in accordance with local, state and federal laws, regulations and policies and to align work with national and **Public Health Accreditation Standards**.
3. **Quality Improvement** Capabilities. **Ability to** evaluate programs and continuously improve processes.
4. Information Technology Capabilities. **Ability to** develop, maintain and access electronic health information to support operations and analyze health data. Ability to support, maintain and use communication technology.
5. Human Resources Capabilities. **Ability to** develop and maintain a competent workforce, including recruitment, retention and succession planning functions; training; and performance review and accountability.
6. Fiscal Management, Contract and Procurement Capabilities. **Ability to** comply with federal, state, and local standards and policies.
7. Facilities and Operations. **Ability to** procure, maintain, and manage safe facilities and efficient operations.
8. Legal Capabilities. **Ability to** access and appropriately use legal services in planning and implementing public health initiatives.

FOUNDATIONAL PROGRAMS

G. Prevention and Control of Communicable Disease and Other Notifiable Conditions.

The functional definition of this foundational program includes:

1. Provide timely, statewide, locally relevant and accurate information statewide and to communities on prevention and control of communicable disease and other **notifiable conditions**.
2. Identify statewide and local community assets for the control of communicable diseases and other **notifiable conditions**, develop and implement a prioritized control plan addressing communicable diseases and other **notifiable conditions** and seek resources and advocate for high priority prevention and control policies and initiatives regarding communicable diseases and other **notifiable conditions**.
3. Promote immunization through evidence-based strategies and collaboration with schools, health care providers and other community partners to increase immunization rates.
4. Ensure disease surveillance, investigation and control for communicable disease and **notifiable conditions** in accordance with local, state and federal mandates and guidelines.
5. Ensure availability of public health laboratory services for disease investigations and response, and reference and confirmatory testing related to communicable diseases and **notifiable conditions**.
6. When **additional important services** are delivered regarding prevention and control of communicable disease and other **notifiable conditions**, ensure that they are well coordinated with foundational services.

H. Chronic Disease, Injury and Violence Prevention.

The functional definition of this foundational program includes:

1. Provide timely, state and locally relevant and accurate information statewide and to communities on chronic disease (including behavioral health), injury and violence prevention.
2. Identify state and local chronic disease (including behavioral health), injury and violence prevention community assets; develop and implement a prioritized prevention plan and seek resources and advocate for high priority policy initiatives to reduce statewide and community rates of chronic disease, injury and violence.
3. When **additional important services** are delivered regarding chronic disease, injury, and violence prevention, **assure** that they are well coordinated with foundational services.

I. Environmental Public Health.

The functional definition of this foundational program includes:

1. Provide timely, state and locally relevant and accurate information statewide and to communities on environmental public health issues and health impacts from common environmental or toxic exposures.
2. Identify statewide and local community environmental public health assets and partners, and develop and implement a prioritized prevention plan to protect the public's health by preventing and reducing exposures to health hazards in the environment, seek resources and advocate for high priority policy initiatives.
3. Conduct environmental public health investigations, inspections, sampling, laboratory analysis and oversight to protect food, **recreational water**, drinking water and liquid waste and solid waste systems in accordance with local, state and federal laws and regulations.
4. Identify and address priority notifiable zoonotic conditions (e.g. those transmitted by birds, insects, rodents, etc.), air-borne conditions and other public health threats related to environmental hazards.
5. Protect the population from unnecessary radiation exposure in accordance with local, state and federal laws and regulations.
6. Participate in broad land use planning and sustainable development to encourage decisions that promote positive public health outcomes
7. When **additional important services** are delivered regarding environmental public health, **assure** that they are well coordinated with foundational services.

J. Maternal/Child/Family Health.

The functional definition of this foundational program includes:

1. Provide timely, statewide and locally relevant and accurate information statewide and to communities on emerging and ongoing maternal, child and family health trends, taking into account the importance of childhood adversity and health inequities.
2. Identify local maternal, child and family health community assets, develop a prioritized prevention plan using life course **expertise** and an understanding of health inequities, seek resources and advocate for high priority policy initiatives.
3. Assure mandated newborn screening done by the state public health lab to test every infant born in Washington to detect and prevent the developmental impairments and life-threatening illnesses associated with congenital disorders that are specified by the State Board of Health. (state function only)
4. When **additional important services** are delivered regarding maternal, child, and family health, **assure** that they are well coordinated with foundational services.

K. Access/Linkage with Medical, Oral and Behavioral Health Care Services.

The functional definition of this foundational program includes:

1. Provide accurate timely, statewide and locally relevant information statewide and to communities on the medical, oral and behavioral health care system.
2. Participate actively in local, regional and state level collaborative efforts regarding medical, oral and behavioral systems planning to improve health care quality and effectiveness, reduce health care costs and improve population health.
3. Improve patient safety through inspection and licensing of health care facilities and licensing, monitoring and discipline of health care providers. (State function only)
4. When **additional important services** are delivered regarding medical, oral and behavioral health, **assure** that they are well coordinated with foundational services.

L. Vital Records.

The functional definition of this foundational program includes:

1. In compliance with state law and in concert with local, state and national groups, **assure** a system of vital records. (State function only)
2. Provide certified birth and death certificates in compliance with state law and rule.



Washington Foundational Public Health Services Functional Full Definitions

A. Assessment (Surveillance and Epidemiology)

The functional definition of this foundational capability includes:

1. Ability to collect sufficient data and develop and maintain electronic information systems to guide public health planning and decision making at the state, regional and local level.

Foundational data include (but are not limited to):

- Behavioral Risk Factor Surveillance System (BRFSS),
- Healthy Youth Survey (HYS), and
- Vital statistics.

Foundational information systems include:

- Washington Disease Reporting System (WDRS),
- Washington Electronic Lab Reporting System (WELRS), and
- Selected clinical data systems (e.g. Comprehensive Hospital Abstract Reporting System [CHARS] and Community Health Assessment Tool [CHAT]).

Data and Data Systems and Analysis

- a. Assure access to public health informatics capability.
- b. Develop and implement policies and procedures to standardize and promote best practices related to data systems, analytic methods and tools to promote data quality, accuracy and timeliness statewide.
- c. Maintain **ability to** collect primary data and share it with Tribal Nations and governmental public health authorities.
- d. Develop and maintain up-to-date electronic information systems for public health surveillance for statewide notifiable disease reporting and investigation (e.g. WDRS).
- e. Develop and maintain up-to-date electronic information systems for public health surveillance for statewide notifiable disease reporting from laboratories (e.g. Public Health Reporting of Electronic Data [PHRED]).
- f. Develop and maintain up-to-date electronic information systems for public health surveillance for statewide collection of selected clinical data sets such as real-time Emergency Room, sentinel outpatient and hospitalization records and hospital discharge data (e.g. CHARS).
- g. Develop and maintain up-to-date electronic information systems for public health surveillance online data analysis of individual data sets and online compilation and analysis of multiple health-related data sets to support governmental agencies in understanding the health of communities and people (e.g. CHAT).

- h. Ensure collection of behavioral data via the BRFSS (annual) and HYS (biennial), including as appropriate:
 - Work with partners to design survey questions and parameters within the funds available.
 - Oversee contracts to administer the survey.
 - Coordinate the data collection.
 - Prepare data for independent analyses by stakeholders.

Reporting, Communications, and Policy

- i. Ensure access to shared data between Tribal Nations and governmental public health authorities that pertain to the health status of the population they serve.
- j. Provide training and technical assistance to local health jurisdictions and community partners on the use of foundational data for assessment.

Prepare for Future Data Needs

- k. Fulfill future data needs using multiple methods and sources for data collection, analysis and presentation using evolving technology with near real-time data displayed using visualization tools and GIS to meet user's requests.
- l. Develop and adapt data systems as needed.

2. Ability to access, analyze, use and interpret data, including:

- U.S. Census,
 - Vital Statistics,
 - Notifiable condition data,
 - Selected clinical data sets including Comprehensive Hospital Abstract Reporting System (CHARS),
 - Behavioral Risk Factor Surveillance System (BRFSS),
 - Healthy Youth Survey (HYS),
 - Basic community and environmental health indicators, and
 - Financial data.
- a. Develop and implement policies and procedures to standardize and promote best practices related to data systems, analytic methods and tools to promote data quality, accuracy and timeliness.
 - b. Analyze data, prepare and publish standardized reports and report on specific topics as needed. Assure accuracy of data and interpretation.
 - c. Produce summaries on key indicators of community health, which include information about social determinants of health.

- d. Provide and use the results of health data analysis (including inequities) to develop culturally appropriate recommendations regarding public health policies, processes, programs or interventions.
- e. Facilitate the sharing of data, resources and **expertise** through partnerships and relationships.
- f. Maintain **24/7 access** to public health surveillance system. Maintain and implement written processes and/or protocols to collect surveillance data from multiple sources and to review and analyze those data, and report out the data, including how they are collected.
- g. Assist agency leadership with identification of health priorities and policies based on data analysis, scientific literature, best practices and promising practices.
- h. Provide scientific and epidemiologic **expertise** to support leadership.
- i. Provide technical assistance to other governmental public health entities and partners regarding access, use, analysis and interpretation of data related to protecting and improving the public's health.
- j. Include protocols for confidentiality as appropriate, and **assure** consistency in adherence to data sharing agreements and security policies.
- k. Prioritize and respond to information and data requests and translate data into information and reports that are valid, statistically accurate and readable by the intended audiences.

3. Ability to conduct a comprehensive community or statewide health assessment and identify health priorities arising from that assessment, including analysis of health disparities and the social determinants of health.

- a. Conduct a comprehensive **state health assessment (SHA)** every three to five years in conjunction with the **governmental public health system** and other statewide partners.
- b. Conduct a local and/or regional comprehensive **community health assessment (CHA)** every three to five years in conjunction with community partners.
- c. Develop a **state health improvement plan (SHIP)** in conjunction with the **governmental public health system** and other statewide partners.
- d. Develop a local and/or regional **community health improvement plan (CHIP)** in conjunction with community partners.

B. Emergency Preparedness (All Hazards)

The functional definition of this foundational capability includes:

1. Ability to develop emergency response plans for natural and man-made public health hazards, train public health staff for emergency response roles and routinely exercise response plans.

- a. Maintain **written procedures for Emergency Support Function 8 – Public Health & Medical (ESF8)** in the State or County **Comprehensive Emergency Management Plan (CEMP)** and/or the **Public Health Response Plan**.
- b. Develop and sustain local and state-level emergency response teams to provide surge capacity in the areas of environmental public health, epidemiology and surveillance, medical countermeasures response, incident command, radiological response, health care response and emergency medical services (EMS) response. Ensure teams are rostered, trained and exercised annually.
- c. Develop and sustain local and statewide mutual aid and partnership agreements with and among **governmental public health system** and Tribal Nations pharmacies, health care organizations, private sector, community organizations and other state agencies.
- d. Develop and maintain a **public health preparedness training and exercise plan**.
 - Conduct training and exercise on the jurisdiction's **ESF8** response plans, public health plan and policies for staff who serve in the agency or jurisdiction Emergency Operations Center (EOC).
 - Ensure training addresses how the **ESF8** response and public health response is coordinated within the jurisdiction's incident command system.
 - Write after action reports (AARs) documenting lessons learned from exercises. Identify corrective actions and track progress in completing those actions.
- e. Train appropriate public health emergency response staff on information management systems used by public health and emergency management agencies.
- f. Maintain a continuity of operations plan (COOP) for the agency. Plans include definition and identification of essential services, line of succession, written delegation of authority for select critical positions and protocols for temporarily discontinuing specific functions to sustain critical services.
- g. Plan or participate in, and document, annual emergency preparedness exercises. Include community partners such as schools, hospitals, emergency management, first responders, community organizations and organizations serving priority populations in exercise design and implementation.

2. Ability to lead the Emergency Support Function 8 – Public Health & Medical and/or a public health response for the county, region, jurisdiction and state.

- a. Develop, train and exercise a decision-making protocol to support agency leadership in making policy-level decisions during public health incidents.
- b. Develop and maintain strategic partnerships with local agencies, non-profit organizations, private sector, health care organizations, state agencies and associations to support public health preparedness, recovery and resilience efforts.
- c. Define roles and responsibilities of public health leaders in establishing short-term and long-term community recovery goals.

3. Ability to activate and mobilize public health personnel and response teams; request and deploy resources; coordinate with public sector, private sector and non-profit response partners and manage public health and medical emergencies utilizing the incident command system.

- a. Establish and maintain a process for **24/7 access**, including coverage and availability, for urgent public health issues.
- b. Maintain an emergency notification system (e.g. WASECURES, E911 Dispatch, or similar system) and include all critical public health response and leadership positions, and essential partners as appropriate, as registered users.
- c. Conduct routine staff notification exercises, evaluate results, address issues and make improvements.
- d. Maintain procedures for requesting assistance during disasters from the local or state Emergency Operations Center (EOC) and mutual aid partners.
- e. Use the incident command system to:
 - Determine objectives to address the health needs of those affected,
 - Develop situational assessments to determine the functionality of critical public health operations, critical health care facilities, critical infrastructure, and the number of ill, injured, and deceased,
 - Identify and allocate resources to address public health needs,
 - Return to routine operations, and
 - Write after action reports documenting lessons learned from real life activations of plans. Identify corrective actions and track progress in completing those actions.
- f. Maintain and exercise procedures and agreements with health care, private sector and community partners to request, receive, distribute and dispense medical countermeasures for statewide and community-wide public health incidents.

4. Ability to communicate with diverse communities across different media, with emphasis on populations that are disproportionately challenged during disasters, to promote resilience in advance of disasters and protect public health during and following disasters.

- a. Maintain and annually exercise procedures and various tools to inform the public of threats to health and safety in a manner that is culturally and linguistically appropriate.
- b. Create and maintain templates for news releases and social media posts for categories of public health hazards.
- c. Work with community leaders, partners, and organizations serving priority populations to communicate public health and health care preparedness, recovery and resilience efforts.

C. Communication

The functional definition of this foundational capability includes:

1. Ability to engage and maintain ongoing relations with local and statewide media.

- a. Develop and maintain a **media relations plan** and policies for leveraging media in communicating with the public effectively.
- b. Build and maintain relationships with media outlets.

2. Ability to develop and implement a communication strategy, in accordance with Public Health Accreditation Standards,⁴ to increase visibility of public health issues. This includes the ability to provide information on health risks, healthy behaviors and disease prevention in culturally and linguistically appropriate formats for the various communities served.

Communications Strategy

- a. Develop and implement a communication plan that includes strategies that describe the role and responsibilities of public health, including the mission and value.
- b. Apply health education and behavior change principles and audience research and analysis to develop communication strategies and plans. This includes using data about the demographics of the general community and specific populations to tailor communication to specific audiences, such as policy makers, stakeholders, local public health authorities, health care providers, the public and specific population groups.
- c. Maintain a list of staff or contractors who provide interpretation, translation or other specific communication services.
- d. Upon request, provide technical assistance to programs and LHJs on the development of communication plans and strategies.
- e. Make health information accessible by using communication channels preferred by target audiences, including a public-facing website, social media platforms, text messaging and other mobile platforms.
- f. Provide a notification system for public health updates or advisories and a **24/7** contact numbers for reporting health emergencies.

⁴ Messages, communication products and distribution methods shall be in compliance with ADA Section 508 and consider health literacy, language, literacy, culture and other aspects of ensuring communication is appropriate to the needs of the intended audience.

- g. Support ongoing public interaction by ensuring that communications allow for two-way communications with the public (e.g. contact information, surveys, comment boxes, phone, social media and community engagement meetings).
- h. Evaluate the effectiveness of communications efforts using tools such as web analytics, surveys or polls. Adjust communications and communications strategies accordingly.
- i. Inform and/or coordinate communications between LHJs, state government, national organizations and federal agencies, including the Centers for Disease Control and Prevention.

Regular and Ongoing Communications

- j. Provide routine communications to the public.
- k. Maintain an up-to-date public website and social media platforms (e.g. Twitter, Facebook and blogs, etc.) that can provide public health information, as part of regular monitoring and responding to community concerns, both routinely and during an emergency.

Emergency Communications Response:

- l. Have, test, use and maintain an **emergency communication plan** with defined policies and procedures.
- m. Establish or participate in an alert network or similar system to receive and issue alerts **24/7**.

D. Policy Development and Support

The functional definition of this foundational capability includes:

- 1. Ability to develop basic public health policy recommendations. These policies must be evidence-based, or, if innovative/promising, must include evaluation plans.**
 - a. Identify and incubate locally-appropriate, evidence-based policy, systems and environmental change strategies to improve health outcomes or innovative/promising strategies using an established policy change framework that includes problem identification, policy analysis, strategy and policy development, policy enactment, policy implementation and policy evaluation.
 - b. Develop a **strategic policy agenda** that includes specific strategies to improve public health at the system level. The plan should contain strategic policy priorities and goals and should align with other plans (e.g. health improvement plan, strategic plan) but can also include policy goals not related to other plans if appropriate.
 - c. Monitor emerging public health issues, conduct policy analysis and develop policy positions in concert with local, state and national partners.
 - d. Take a leadership role for communication about how policy changes may impact health.
 - e. Access literature, journals and research on evidence-based policy options.
- 2. Ability to work with partners and policy makers to enact policies that are evidence-based (or are innovative and/or promising and include evaluation plans) and that address the social determinants of health and health equity.**
 - a. Coordinate local, state and federal public health policy agendas where appropriate to intentionally advance health equity.
 - b. Develop and implement the **strategic policy agenda** through agency/organization policy, new/revised public health programs, development/proposal of guidelines, rules, regulations or laws that used evidence-based or innovative/promising practices with a focus on eliminating health, racial, income, geographic and other inequities.
 - c. Analyze, interpret and respond to proposed policy, and, if enacted, implement local, state and federal policy changes. Describe the impact on public health and health equity.
 - d. Coordinate within the **governmental public health system** and with federal agencies and other partners on policies that affect public health and health equity.
 - e. Provide support (e.g. information sharing and technical assistance) to policy leads working in local organizations and, upon request, participate in policy initiatives including those that include multiple organizations.

- f. Provide access to public health law consultation and technical assistance (e.g. state attorney general and legal technical assistance groups).
- g. Analyze pending legislation, estimate costs for new work, provide data and information as requested by lawmakers and testify on proposed policy changes if appropriate.
- h. Review existing laws and work with governing entities and elected/appointed officials to update as needed.
- i. Monitor and/or track policies under consideration by the regulatory authority, elected officials, government officials and/or other entities that set policies and practices that impact public health.
- j. Evaluate implemented policies to determine whether policy goals were met and use findings to improve and/or revise policies.

3. Ability to utilize cost-benefit information to develop an efficient and cost-effective action plan to respond to the priorities identified in a community and/or statewide health assessment.

- a. Access resources to develop and/or make available economic analyses (e.g. cost and/or risk of non-investment, return on investment) for proposed policy changes at the local and/or state level.
- b. Ensure access to experts to evaluate the social and economic impact of public health policies (e.g. contracts with economists, if needed).

E. Community Partnership Development

The functional definition of this foundational capability includes:

1. Ability to create and maintain relationships with diverse partners, including health-related national, statewide, and community-based organizations; community groups or organizations representing populations experiencing health inequity; private businesses and health care organizations; Tribal Nations and local, state and federal government agencies and leaders.

- a. Create and maintain relationships with and convene cross-sector and cross-cultural stakeholders to establish shared local or statewide priorities, identify a common vision and values and build partnerships to develop and implement coordinated activities to address priority public health issues, with attention to health equity.
- b. Evaluate the effectiveness of cross-sector and cross-cultural partnerships in a culturally appropriate way, including evaluating DOH or LHJs as partners. As part of evaluation efforts, address successes, lessons learned, recognized barriers to such collaboration and strategies to overcome these barriers.

Cross-sector stakeholders may include:

- Health-related organizations and health systems;
- Planning and transportation agencies;
- Agriculture and other food systems;
- Private businesses;
- Schools and early learning settings;
- Local and state community groups and organizations; and
- Local, state, and federal public health, Tribal Nations, and other governmental agencies.

2. Ability to select and articulate governmental public health roles in programmatic and policy activities and coordinate with these partners.

- a. Convene public health and cross-sector and cross-cultural partners to promote health and address public health issues and health equity.
- b. Coordinate policy agendas⁵ with partner organizations to advance cross-cutting, strategic goals.

⁵ See Policy Development and Support, Element 1, Activity c (D.1.c.).

- c. Engage affected communities⁶ in developing policy and conducting community/state health assessments and developing health improvement plans to ensure efforts to leverage community resources are community-oriented and culturally-appropriate.

⁶Those affected by the policy and entities/sectors that impact the policy.

F. Business Competencies

The functional definition of this foundational capability includes:

1. Leadership Capabilities. Ability to lead internal and external stakeholders to consensus and action planning (adaptive leadership) and to serve as the public face of governmental public health in the community.

- a. Provide leadership and managerial oversight to the agency.
- b. Engage in public health policy development, discussion and adoption with local, state and national policy makers to help define the strategic direction of public health initiatives.
- c. Lead collaborations with external and cross-sector partners to develop a vision for a healthy community.
- d. Develop and implement a governmental public health authority-specific strategic plan to guide resource allocation for strategic priorities.
- e. Convene members of the **governmental public health system** and partners to create opportunities to work together to improve the public's health.
- f. In collaboration with partners and stakeholders, set the strategic direction and goals for the **governmental public health system** in Washington.

2. Accountability and Quality Assurance Capabilities. Ability to uphold business standards and accountability in accordance with local, state, and federal laws, regulations and policies and to align work with national and Public Health Accreditation Standards.

- a. Develop and implement written operations policies and procedures, including organizational charts.
- b. Develop and implement policies and procedures that relate to identification and resolution of ethical issues.

3. Quality Improvement Capabilities. Ability to evaluate programs and continuously improve processes.

- a. Use performance management, **quality improvement** tools and coaching to promote and monitor organizational objectives and sustain a culture of quality.
- b. Develop and maintain performance standards, including goals, targets and performance measures.
- c. Collect, maintain and analyze longitudinal data on defined performance measures.

- d. Collect, maintain and analyze feedback from customers.
- e. Use performance data to inform **quality improvement** and program planning.
- f. Communicate goals, targets and performance measures to **governmental public health**, elected officials and the public.
- g. Generate regular progress reports that analyze data and communicate performance results.
- h. Assist public health programmatic staff and content experts with the development and collection of performance measures used to monitor performance over time.
- i. Provide subject matter **expertise** to programs, agencies and partners regarding:
 - Meaningful milestones, performance measures, targets and goals for which the appropriate level and frequency of data is available.
 - Monitoring, evaluating, analyzing and reporting on performance measures.
 - Use of **quality improvement** methods and other tools and techniques, such as Lean, to improve performance.
 - Use of financial data, as appropriate, in program evaluation, program design, organization and delivery.
 - Literature and resources on the efficiency and effectiveness of alternate structures or processes for delivering services, including published program evaluations and related evidence-based research.
- j. Evaluate the efficacy and efficiency, including the financing, organization/structure and delivery of public health policies, programs, strategies, interventions and processes using a variety of evaluation approaches and frameworks.
- k. Produce summaries describing the impact of public health policies, programs and strategies on health outcomes, including economic analyses, when appropriate.

4. Information Technology Capabilities. Ability to develop, maintain and access electronic health information to support operations and analyze health data. Ability to support, maintain, and use communication technology.

- a. Develop and maintain public health system-wide and local technology and resources⁷ that supports current and future public health practice needs including **ability to** collect public health surveillance data, conduct robust analyses and make results available to the public.

⁷ Computer Hardware, tables, mobile computing, software (e.g. Office 365), phone systems, secure e-mail, webcam, Rapid Health Information NetwOrk (RHINO) Syndromic Surveillance.

- b. Use and disseminate protocols based on best practices to ensure privacy and protection of personally identifiable and/or confidential health information in data systems and information technology.
- c. Develop, use and maintain communication technologies needed to interact within the agency and externally with partners and the public.
- d. Develop and maintain agreement(s) between **governmental public health** and other data providers to share data relevant to public health.

5. Human Resources Capabilities. Ability to develop and maintain a competent workforce, including recruitment, retention and succession planning functions; training; and performance review and accountability.

- a. Assure access to staff with the necessary knowledge, skills and abilities to perform the essential functions of **governmental public health** with ongoing access to training and supervision.
- b. Support overall workforce development by providing resources to improve the skills, capabilities and leadership of the public health workforce.
- c. Develop public health leaders to effectively support and manage the workforce from hire to retire.
- d. Develop and maintain a human resources manual or set of human resources policies and procedures.
- e. Provide or have access to adequate human resources support, including recruitment, retention, succession planning, training, performance review and other necessary human resource activities to meet program needs.
- f. In **governmental public health** authorities with staff represented by collective bargaining units, develop and maintain productive relationships with collective bargaining units; engage in collective bargaining negotiations as appropriate and ensure access to labor relations **expertise** as needed.
- g. Develop and implement a workforce development plan that identifies needed technical and/or informatics skills, competencies and/or positions. Include action plans for recruiting, hiring and/or developing existing staff to meet the needs of and reflect the ethnic, linguistic and cultural aspects of the population served.
- h. Coordinate, or perform when necessary, assessments of leadership and organizational capabilities to understand **capacity**, identify gaps and develop strategies to address gaps.
- i. Support leaders and employees in understanding equity principles and using inclusionary practices in all aspects of workforce management and workforce culture.

6. Fiscal Management, Contract and Procurement Capabilities. Ability to comply with federal, state and local standards and policies.

- a. Develop and maintain financial management and procurement manuals documenting organizational policies and procedures.
- b. Establish and maintain budgeting, billing, contracting and financial system(s) in compliance with local, state and federal standards and policies.
- c. Produce and monitor an effective governmental public health authority-specific budget.
- d. Provide financial management, contract and procurement services, including maintaining records, in accordance with generally accepted accounting principles (GAAP), governmental accounting standards board (GASB) or other compliance requirements.
- e. Ensure access to auditing services to evaluate financial management practices and transparency around collection of revenues and disposition of expenditures.
- f. Conduct sound financial analyses to inform decisions about policies, programs and services.

7. Facilities and Operations. Ability to procure, maintain and manage safe facilities and efficient operations.

- a. Maintain safe, secure and clean facilities in compliance with all relevant laws.
- b. Develop plans for future facility and space requirements that align with operational needs.
- c. Plan for, acquire and maintain fleet vehicles.
- d. Ensure compliance with local, state and federal laws concerning facility accessibility.

8. Legal Capabilities. Ability to access and appropriately use legal services in planning and implementing public health initiatives.

- a. Provide or have access to legal services and analysis to support development and enforcement of public health rules, regulations, policies and legislation.
- b. Advocate to and collaborate with governing bodies, including boards of health, county commissioners and the governor and state legislature.

G. Prevention and Control of Communicable Disease and Other Notifiable Conditions⁸

The functional definition of this foundational program includes:

1. Provide timely, statewide, locally relevant and accurate information statewide and to communities on prevention and control of communicable disease and other notifiable conditions.

Data and Data Systems and Analysis

- a. Collect and maintain communicable disease, other **notifiable conditions** and immunization data to support prevention and control of communicable diseases and other **notifiable conditions** at the state and local level.
- b. Develop and maintain up-to-date electronic statewide Immunization Information System (IIS). (Centralized activity – currently provided by DOH)
- c. Conduct data entry, validation / clean-up and maintenance as needed to ensure data quality.
- d. Access, analyze, and use immunization data to inform evidence-based interventions.
- e. Develop and implement protocols for data and information sharing between public health, health care providers (pharmacists and veterinarians when appropriate), other local, state and federal agencies and the public to reduce disease transmission and increase immunization rates. Include protocols for confidentiality as appropriate.
- f. Ensure that health care providers, pharmacists, school officials and the public are educated about the statewide IIS and how to enter, maintain and access correct data, as appropriate to ensure data quality.
- g. Analyze, interpret and share communicable disease, other **notifiable conditions** and immunization data, including data pertaining to inequities.

Reporting, Communications, and Policy

- h. Measure the impact of communicable disease and other **notifiable conditions** and immunization rates on the health of the public, including priority populations.
- i. Ensure health care facilities, health care providers, veterinarians and laboratories are educated about **notifiable conditions** requirements including the need for timely and accurate reporting and how to report.

⁸ The full current list of notifiable conditions is available here:
<https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/NotifiableConditions>.

- j. Maintain **capacity** to prioritize and respond to data requests and as appropriate, prepare data files to share and make available to researchers and other stakeholders.
- k. Produce and share periodic/routine reports of communicable disease and other **notifiable conditions** and immunization rates.
- l. Inform decision makers of potential and actual impacts to public health based on communicable disease and other **notifiable conditions** data, immunization rates and published reports.
- m. Provide the public, regulated facilities, health care facilities, health care providers and stakeholder organizations effective and timely communication about protection recommendations for communicable disease and other **notifiable conditions** while balancing the need to protect personal health information.
- n. Use data, evidence-based practices and community input to facilitate development of public health policy, systems and environmental change initiatives for communicable disease, other **notifiable conditions** and immunization rates, including those designed to promote health equity.

Prepare for Future Data Needs

- o. Fulfill future data needs using multiple methods and sources for data collection, analysis and presentation using evolving technology with near real-time data displayed using visualization tools and GIS to meet user's requests.
- p. Ability to develop and adapt data systems as needed.

2. Identify statewide and local community assets for the control of communicable diseases and other notifiable conditions, develop and implement a prioritized control plan addressing communicable diseases and other notifiable conditions and seek resources and advocate for high priority prevention and control policies and initiatives regarding communicable diseases and other notifiable conditions.

- a. Provide subject matter **expertise** to inform policy, system and environmental change; program design and communications to decision/policy makers, providers, the public and stakeholders about communicable disease and other notifiable condition risks.
- b. Identify, develop, engage and maintain local strategic partnerships with health care facilities, health care providers, pharmacists, long-term care facility staff, infection control specialists, school officials, the public and others to prevent, control and mitigate risks from communicable disease and other **notifiable conditions**.
- c. Identify, develop, engage, and maintain strategic partnerships with statewide organizations, associations, and government agencies to prevent, control, and mitigate risk from communicable disease and other **notifiable conditions**.

- d. Identify, develop, engage and maintain relationships with academic institutions and/or research centers to advance evidence-based practice and innovations related to disease prevention, control and mitigation.
- e. Work with partners to develop a prioritized control plan(s) addressing important communicable disease and other **notifiable conditions**, and immunization rates, as needed.
- f. Work with partners to advocate for high priority policy, system and environmental change and other initiatives regarding communicable diseases and other **notifiable conditions**.

3. Promote immunization and use of the statewide immunization registry through evidence-based strategies and collaboration with schools, health care providers and other community partners to increase immunization rates.

- a. Provide subject matter **expertise** to inform policy, systems and environmental change, program design, and communications to decision/policy makers, providers, the public and stakeholders about vaccine preventable disease and immunizations.
- b. Ensure that health care providers, pharmacists, long-term care facility staff, infection control specialists, school officials, the public and others are educated about vaccine-preventable diseases, immunizations and use of the statewide immunization registry called the Immunization Information System (IIS).
- c. Develop, implement, and enforce laws, rules, policies and procedures related to immunizations per local, state and federal mandates and guidelines (e.g. school/work exclusion, isolation and quarantine).
- d. Identify, develop, engage and maintain local strategic partnerships with health care providers, pharmacists, long-term care facility staff, infection control specialists, school officials, the public and others to use evidence-based strategies that are culturally and linguistically appropriate to increase immunization rates in children and adults and in communities that are disproportionately impacted by low immunization rates.
- e. Identify, develop, engage and maintain strategic partnerships with statewide organizations, associations and government agencies to use evidence-based strategies that are culturally and linguistically appropriate to increase immunization rates in children and adults and in communities that are disproportionately impacted by low immunization rates.
- f. Identify, develop, engage, and maintain relationships with academic institutions and/or research centers to advance evidence-based practice and innovation regarding immunizations.
- g. Work with partners to develop a prioritized plan addressing important immunization issues.

- h. Work with partners to advocate for high priority policy, system, and environmental change initiatives regarding immunizations.

4. Ensure disease surveillance, investigation, and control for communicable disease and notifiable conditions in accordance with local, state and federal mandates and guidelines.

- a. Notify health care providers, laboratories and health care facilities within the jurisdiction about the requirements related to **notifiable conditions**.
- b. Establish and maintain **24/7 access** to receive and respond to case reports in a timely manner according to Washington Administrative Code (WAC) and Revised Code of Washington (RCW) timeframes.
- c. Maintain written protocols and procedures for conducting investigations of suspected or identified public health problems/hazards including investigation steps, responsible parties, timelines, handling and submission of specimens, communication with the public health lab and coordination with other applicable agencies. These should address in addition how the principal health care provider will be notified, the use of prophylaxis, the process of exercising legal authority for disease control, internal and external communication.
- d. Utilize scientific methods and best practices, when indicated, to collect environmental samples and human specimens for laboratory analysis to confirm or rule out disease presence. This includes packaging in conformance with DOT and USPS requirements and shipping to a certified laboratories for analysis.
- e. Receive case reports and other identifiable data from a variety of providers and laboratories and other reporters.
- f. Include protocols to ensure confidentiality of protected health information throughout inspection, investigation, reporting and maintenance of data.
- g. Develop and maintain a system/process to communicate rapidly with health care providers during public health emergencies.
- h. Evaluate disease control investigations and response and use findings to improve response processes and procedures.
- i. Provide consultation and technical assistance to other local and state agencies and the general public. Provide disease-specific and technical **expertise** regarding epidemiologic and clinical characteristics of diseases of public health significance to health care professionals, veterinarians, and others. Advise health care practitioners about evidence-based practices for communicable disease and other **notifiable conditions** diagnosis, treatment, control and prevention.

Disease Surveillance and Investigation

- j. Develop, implement and enforce laws, rules, policies and procedures related to the investigation and control of communicable diseases and other **notifiable conditions** per federal, state and local mandates and guidelines (e.g. school/work exclusion, isolation and quarantine).
- k. Monitor occurrence and distinguishing characteristics and trends of communicable diseases and other **notifiable conditions** to identify outbreaks and other emerging events (e.g. disease clusters, source and geographical region).
- l. Conduct or assist with outbreak investigations that have a communicable disease or other notifiable condition component. Maintain outbreak response and control protocols, including accessing resources and assistance after normal work hours.
- m. Conduct timely investigation of complaints related to communicable disease or other **notifiable conditions**, including ensuring **capacity** to identify and respond to rare or previously unidentified infections (conditions for which formal protocols do not yet exist) or novel modes of transmission. Maintain **capacity** (including a system/process) for prioritization and respond to investigate cases and control disease outbreaks within the jurisdiction, in collaboration with partners.
- n. Maintain a tracking log of all case reports and investigations.

Specific Conditions of Public Health Importance

- o. Provide partner notification services for newly diagnosed cases of syphilis, gonorrhea, Hepatitis C and HIV, according to Centers for Disease Control and Prevention (CDC) guidelines.
- p. Provide surveillance, disease investigation and control (including partner services and linkage to curative treatment) for Hepatitis C, according to CDC guidelines.
- q. Maintain adequate **expertise** and resources to ensure the identification and appropriate treatment of individuals who have latent tuberculosis (TB) infection and active tuberculosis, including the provision of directly-observed therapy for active TB according to CDC guidelines.
- r. Provide education to and coordinate with health care providers to ensure appropriate screening, reporting and treatment of TB.
- s. Maintain the **ability to** identify and provide education for a community provider willing to treat latent TB.
- t. Conduct timely contact investigation for all active pulmonary TB cases per state guidelines.
- u. Review overseas medical records and chest radiographs on all class B immigrants; if needed, perform additional evaluation to ensure active disease is ruled out.
- v. Maintain access to consultation with a public health physician with experience in diagnosis and treatment of TB as well as contact investigations.

New and Emerging Conditions and Emergencies

- w. Develop and implement plans to identify and respond to emerging infectious diseases (e.g. Severe Acute Respiratory Syndrome [SARS], Middle East Respiratory Syndrome [MERS] and Ebola).
- x. Coordinate communicable disease and other **notifiable conditions** public health efforts with Tribal Nations and federal and state partners (e.g. CDC, U.S Food and Drug Administration [FDA], U.S. Department of Agriculture [USDA], U.S. Environmental Protection Agency [EPA], Washington State Department of Ecology and Washington State Department of Agriculture).
- y. Ensure the **ability to** recognize instances of potential biological terrorism and conduct and coordinate appropriate investigations, laboratory testing, and management of exposed persons in collaboration with first responder and law enforcement agencies.
- z. Develop action plans for communicable disease and other **notifiable conditions** emergencies.
- aa. Develop, maintain and coordinate to provide **surge capacity** to other public health agencies during emergency events or large outbreaks.
- bb. Develop and maintain plans for the allocation of scarce resources and medical countermeasures in the event of an emergency or outbreak in collaboration with the regional health care system.

5. Ensure availability of governmental public health laboratory services for disease investigations and response, and reference and confirmatory testing related to communicable diseases and notifiable conditions. (Centralized activity – currently provided primarily by DOH with support from Public Health – Seattle-King County)

- a. Provide **24/7 access** to laboratory resources to support testing for **notifiable conditions** and outbreak identification, including biological and chemical agents of weapons of mass destruction.
- b. Maintain a current continuity of operations plan (COOP) in the event of a disruption of laboratory services.
- c. Promote and maintain innovative scientific and technological infrastructure⁹ to provide cutting-edge laboratory services to protect and promote the public's health (e.g. next generation sequencing, bioinformatics, and other advanced techniques).
- d. Maintain interdisciplinary collaboration across diverse programs (e.g. epidemiology, preventive health and environmental health) to ensure consistent knowledge and communication on innovation, testing methodologies and results interpretations.

⁹ Maintain the **capacity** to perform isolation, molecular diagnostic testing, and antibiotic susceptibility testing for M. tuberculosis. (State function only)

- e. Maintain and develop, as needed, appropriate laboratory certification and quality assurance, and ensure compliance with relevant accreditation and regulations.
- f. Develop and maintain efficient electronic systems that support data collection, analysis and reporting and **ability to** share confidential lab data within the **governmental public health system** and clinical laboratories. Include protocols for confidentiality as appropriate.
- g. Maintain protocols and provide training for proper collection, preparation, packaging and shipment of samples of public health importance.
- h. Coordinate with local public health laboratories and federal partners (e.g. CDC, FDA, USDA and EPA) in specimen testing, outbreak identification and testing protocols
- i. Develop and maintain **surge capacity** agreements with other public health laboratories (regionally and nationally) to ensure testing **capacity** during emergency events or large outbreaks.
- j. Coordinate with clinical laboratories to promote quality assurance, consistency in testing methodologies, result interpretations and safe laboratory practices among clinical and public health laboratories.

6. When additional important services are delivered regarding prevention and control of communicable disease and other notifiable conditions, ensure that they are well coordinated with foundational services.

- a. Identify and support relationships, interdependencies and coordination needs between the **foundational program** and related **additional important services (AIS)**.
- b. Leverage **foundational program** activities and funding to support identification and implementation of related **AIS** and vice versa.

H. Chronic Disease, Injury and Violence Prevention

The functional definition of this foundational program includes:

1. Provide timely, state and locally relevant and accurate information statewide and to communities on chronic disease (including behavioral health), injury and violence prevention.

Data and Data Systems and Analysis

- a. Collect and maintain data (including risk factors and demographic information) on chronic disease, injuries and violence to support public health functions at the state and local level.
- b. Analyze and interpret, and share public health data regarding chronic disease, injuries and violence including trends, data pertaining to risk factors and inequities.
- c. Develop and implement protocols for data and information sharing between public health, health care providers, Tribal Nations, other local, state, and federal agencies, and the public to reduce chronic disease, injuries and violence. Include protocols for confidentiality as appropriate.
- d. Measure the impact of chronic disease, injuries and violence on the health of the public, including priority populations.
- e. As appropriate, prepare data files to share and make available to researchers and other stakeholders.

Reporting Communications and Policy

- f. Monitor knowledge, attitudes, behaviors and health outcomes related to chronic disease, injuries, and violence and risk factors by using data provided by the state or by conducting surveillance locally.
- g. Inform decision makers of potential and actual impacts to public health from chronic disease, injuries, and violence based on data and published reports.
- h. Produce and share periodic/routine reports of rates of chronic disease injuries, and violence as well as risk factors and inequities.
- i. Provide the public, regulated facilities, and stakeholder organizations effective and timely communication about recommendations to prevent chronic disease, injuries and violence.
- j. Use data and evidence-based practices to facilitate development of public health policy, systems and environmental change initiatives for preventing chronic disease, injuries and violence, including those designed to promote health equity.

Prepare for Future Data Needs

- k. Fulfill future data needs using multiple methods and sources for data collection, analysis and presentation using evolving technology with near real-time data displayed using visualization tools and geographic information systems (GIS) to meet user's requests.
- l. Develop new and adapt existing data systems as needed.

2. Identify state and local chronic disease (including behavioral health), injury and violence prevention community assets; develop and implement a prioritized prevention plan and seek resources and advocate for high priority policy initiatives to reduce statewide and community rates of chronic disease, injury and violence.

- a. Provide subject matter **expertise** to inform policy, systems and environmental change, program design, and communications to decision makers, providers, the public and stakeholders about chronic disease, injury and violence risks.
- b. Develop a community asset map that identifies state and local strategic partnerships, including academic institutions and/or research centers.
- c. Identify, develop, engage and maintain local and statewide strategic partnerships with organizations, associations and government agencies, academic institutions and/or research centers to advance evidence-based practice and innovation to prevent chronic disease, injuries and violence.
- d. Work with partners to review, update and implement a prioritized plan of best and emerging practices aligned with state and national guidelines to address important chronic disease, injury and violence risks and Healthy People¹⁰ federal guidelines objectives.
- e. In concert with local, state and national local health community partners, develop and implement prioritized plans for assuring access to specific chronic disease, behavioral health, injury and violence prevention programs and services of public health importance, such as: Reducing rates of tobacco use through activities to reduce youth initiation, increase cessation and reduce secondhand smoke exposure; Increase statewide and community rates of healthy eating and active living; and Seek resources and advocate for high priority policy initiatives.
- f. Work with partners to advocate for policy, system and environmental change initiatives regarding chronic disease, injury and violence prevention.
- g. Seek funding to implement evidence-based or innovative prevention initiatives.

¹⁰ Healthy People federal guidelines. Available at: <https://www.healthypeople.gov/>.

- h. Periodically evaluate progress on reducing rates of chronic disease, injuries, violence and contributing risk factors and use findings to improve prevention strategies.

3. When additional important services are delivered regarding chronic disease, injury and violence prevention, assure that they are well coordinated with foundational services.

- a. Identify and support relationships, interdependencies and coordination needs between the **foundational program** and related **additional important services (AIS)**.
- b. Leverage **foundational program** activities and funding to support identification and implementation of related **AIS** and vice versa.

I. Environmental Public Health

The functional definition of this foundational program includes:

1. Provide timely, state and locally relevant and accurate information statewide and to communities on environmental public health issues and health impacts from common environmental or toxic exposures.

Data and Data Systems and Analysis

- a. Collect and maintain environmental and human health data to support environmental public health functions at the local and state level, including built environment, chemical, radiological and biological hazards.
- b. Analyze, interpret and share environmental public health data including data pertaining to the built environment and health inequities.
- c. Develop and implement protocols for information sharing between public health, health care providers (including veterinarians), Tribal Nations, other local, state and federal agencies and the public to reduce environmental exposure and disease transmission. Include protocols for confidentiality as appropriate.
- d. As appropriate, prepare data files to share and make available to researchers and other stakeholders.

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- e. Provide the public, regulated facilities and stakeholder organizations effective and timely communication of environmental public health hazards and protection recommendations, such as media releases and public health advisories.
- f. Measure the impact of environmental hazards on the health of the public, including health inequities. Produce and share periodic/routine reports of diseases or other impacts linked to environmental public health issues.
- g. Inform decision makers of potential and actual environmental impacts to public health based on data and published reports.
- h. Use data and evidence-based practices to facilitate development of environmental public health policy, systems and environmental change initiative, including those designed to promote health equity.

Prepare for Future Data Needs

- i. Fulfill future data needs using multiple methods and sources for data collection, analysis and presentation using evolving technology with near real-time data displayed using visualization tools and geographic information systems (GIS) to meet user's requests.
- j. Develop and adapt data systems as needed.

2. Identify statewide and local community environmental public health assets and partners, and develop and implement a prioritized prevention plan to protect the public's health by preventing and reducing exposures to health hazards in the environment, seek resources and advocate for high priority policy initiatives.

- a. Provide subject matter **expertise** to inform policy, system and environmental change, program design and communications that inform decision makers, providers, the public and stakeholders about environmental public health risks.
- b. Identify, develop, engage and maintain local strategic partnerships to prevent and control environmental public health risks.
- c. Identify, develop, engage and maintain strategic partnerships with statewide associations, government agencies and statewide organizations to prevent and control environmental public health risks.
- d. Identify, engage and maintain relationships with academic institutions and/or research centers to advance evidence-based practice and innovation.
- e. Work with partners to develop a prioritized control plan addressing important environmental public health risks.
- f. Work with partners to advocate for high priority policy, system and environmental change initiatives regarding environmental public health and seek funding to implement evidence-based or innovative **additional important services (AIS)** prevention and control initiatives.
- g. Develop action plans for environmental public health emergencies.
- h. Coordinate and/or provide **surge capacity** staffing for cross-jurisdictional environmental public health emergency response.
- i. Coordinate environmental public health efforts with federal and state partners (e.g. Centers for Disease Control [CDC], United States [U.S.] Food and Drug Administration [FDA], U.S. Department of Agriculture [USDA], U.S. Environmental Protection Agency [EPA], Washington State Department of Ecology and Washington State Department of Agriculture). Document implementation of regulations for mandated public health programs.

3. Conduct environmental public health investigations, inspections, sampling, laboratory analysis and oversight to protect food, recreational water, drinking water and liquid and solid waste systems in accordance with local, state, and federal laws and regulations.¹¹

- a. Develop environmental public health regulations per local, state and federal mandates.
- b. Develop, implement and enforce laws, rules, policies and procedures for maintaining the health and safety of retail food service inspections and shellfish monitoring, that address environmental public health concerns.
- c. Develop, implement and enforce laws, rules, policies and procedures for ensuring the health and safety of **recreational water** facilities, including through pool and swimming beach health and safety inspections and water quality sampling and testing, that address environmental public health concerns.
- d. Develop, implement and enforce laws, rules, policies and procedures for ensuring the health and safety of drinking water including through source water protections, water system design review, water system inspections, water quality testing and oversight and plan review to ensure water adequacy, that address environmental public health concerns.
- e. Develop, implement and enforce laws, rules, policies and procedures for ensuring the health and safety of wastewater and facilities, including onsite septic design and inspections, wastewater treatment and reclaimed water, that address environmental public health concerns.
- f. Develop, implement and enforce laws, rules, policies and procedures for ensuring the health and safety of solid waste and facilities, including hazardous waste streams (e.g. animal waste, solid waste permitting and solid waste inspections), that address environmental public health concerns.
- g. Develop, implement and enforce laws, rules, policies and procedures for ensuring the health and safety of schools, including through education and plan review that address environmental public health concerns.

¹¹ Laboratory testing activities are in *G. Prevention and Control of Communicable Disease and Other Notifiable Conditions*.

- h. Develop, implement and enforce laws, rules, policies and procedures for ensuring the health and safety of temporary worker housing, that address environmental public health concerns.
- i. Develop, implement and enforce laws, rules, policies and procedures for ensuring the health and safety of transient accommodations, including through camp inspections, that address environmental public health concerns.
- j. Utilize scientific methods and best practices, when indicated, to collect environmental samples and human specimens for laboratory analysis to confirm or rule out disease presence. This includes packaging in conformance with DOT and USPS requirements and shipping to a certified laboratories for analysis.
- k. Develop, implement and enforce laws, rules, policies and procedures for ensuring compliance with smoking in public places laws, that address environmental public health concerns.
- l. Implement environmental public health regulations including licensing, inspection, public notification and enforcement actions.
- m. Educate individuals and organizations on the meaning, purpose and benefit of public health laws and how to comply.
- n. Conduct or assist with outbreak investigations that have an environmental public health component.
- o. Conduct timely investigation of complaints related to mandated environmental public health programs.
- p. Maintain and implement protocols and systems to ensure confidentiality of protected health information throughout inspection, investigation, reporting and maintenance of data.
- q. Maintain **expertise** and provide consultation to other local and state agencies and the general public.
- r. Evaluate implementation of environmental public health regulations and disease control investigations and response, and use findings to improve processes and procedures.

4. Identify and address priority notifiable zoonotic conditions (e.g. those transmitted by birds, insects, rodents, etc.), airborne conditions and other public health threats related to environmental hazards.

- a. Develop and implement environmental public health regulations, including licensing, investigations, inspections, containment/mitigation, correction and enforcement, per local, state and federal mandates.
- b. As needed, develop and implement plans to identify and respond to emerging zoonotic diseases (e.g. Zika), exposures related to pesticides and other emerging environmental public health issues.

- c. Coordinate containment or mitigation of environmental public health hazards (e.g. air quality and exposures to toxic substances) with other government departments and stakeholders.
- d. Conduct outreach and provide guidance on the occurrence, prevention and control of zoonotic diseases to Local Health Jurisdictions (LHJs), Washington State Department of Agriculture and Fish and Wildlife, veterinarians and others.
- e. Maintain **expertise** and provide consultation to other local and state agencies and the general public about best practices related to vector control.
- f. Coordinate and/or provide **surge capacity** staffing for cross-jurisdictional environmental public health emergency response.

5. Protect the population from unnecessary radiation exposure in accordance with local, state and federal laws and regulations.

- a. Develop environmental public health regulations for radioactive sources per state and federal mandates.
- b. Develop and implement policies and procedures for regulated facility inspections and investigations related to exposure to harmful radioactive sources.
- c. Implement environmental public health regulations including registration, licensing, inspection and enforcement actions.
- d. Conduct timely investigation of complaints related to radioactive sources.
- e. Maintain a trained and equipped radiation emergency response team(s) for radiological emergencies.
- f. Maintain and implement protocols and systems to ensure confidentiality throughout inspection, investigation, reporting and maintenance of data.
- g. Coordinate environmental public health efforts with federal and state partners (e.g. CDC, FDA, USDA, EPA, the Nuclear Regulatory Commission (NRC), Washington State Department of Ecology and Washington State Department of Agriculture).
- h. Provide consultation and technical assistance to LHJs, other agencies and the general public.
- i. Monitor and study radiation levels in the environment air, water, soils, foods and vegetation for possible health effects.
- j. Document implementation of radiation regulations.
- k. Evaluate implementation of radiation regulations and use findings to improve processes and procedures.

6. Participate in broad land use planning and sustainable development to encourage decisions that promote positive public health outcomes.

- a. Maintain relationships with partners in economic development, transportation, parks and land use agencies.
- b. Understand and participate in land use, transportation, natural resources and other planning processes.
- c. Provide technical assistance to planning agencies and community stakeholders to integrate standard environmental public health practices that prevent/reduce high risk for harmful environmental exposures to humans or disease transmission.
- d. Anticipate, analyze and communicate about changes in public health risk and benefits resulting from changes to the built and natural environment and potential impacts of climate change through the collection, analysis and interpretation of health and environmental public health data.
- e. Provide input on potential health and equity impacts of projects, plans, programs or policies to ensure healthy and sustainable built and natural environments.
- f. Document and evaluate integration of standard environmental public health practices into programs and planning processes that prevent high risk for harmful environmental exposures or disease transmission.

7. When additional important services are delivered regarding environmental public health, assure that they are well coordinated with foundational services.

- a. Identify and support relationships, interdependencies, and coordination needs between the **foundational program** and related **AIS**.
- b. Leverage **foundational program** activities and funding to support identification and implementation of related **AIS** and vice versa.

J. Maternal/Child/Family Health

The functional definition of this foundational program includes:

1. Provide timely, statewide and locally relevant and accurate information statewide and to communities on emerging and ongoing maternal, child and family health trends, taking into account the importance of childhood adversity and health inequities.

Data and Data Systems and Analysis

- a. Anticipate future data needs, track new methods of data collection and technology, explore new data sources, identify new uses of data and suggest technological, data architecture, staffing and resource solutions to meet data needs and improve effectiveness and efficiency.
- b. Develop and implement protocols for data and information sharing between public health, health care providers, Tribal Nations, other local, state, and federal agencies and the public. Include protocols for confidentiality as appropriate.
- c. Analyze, interpret and share public health data regarding the status of maternal, child and family health including trends and data pertaining to risk factors and social and health inequities.
- d. Collect and maintain data on health outcomes for preconception, prenatal, natal and postnatal care; childhood, maternal and family health (e.g. Pregnancy Risk Assessment and Monitoring System [PRAMS] and maternal and child death reviews) to support public health functions at the state and local level, including risk factors and demographic information.

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- e. Maintain **capacity** to prioritize and respond to data requests and as appropriate, prepare data files to share and make available to researchers and other stakeholders.
- f. Monitor knowledge, attitudes, behaviors and health outcomes related to maternal, child and family health and risk factors by using data provided by the state or by conducting surveillance locally.
- g. Produce and share periodic/routine reports on the status of the health of mothers, children and families as well as risk factors that impact their health.
- h. Inform decision makers of potential and actual impacts to maternal, child and family health and contributing factors based on data and published reports.
- i. Provide the public, health system partners and stakeholder organizations effective and timely communication about recommendations to protect and improve maternal, child and family health.

- j. Use data, emerging science (e.g. neuroscience, epigenetics, Adverse Childhood Experiences, resilience) and evidence-based practices to facilitate development of public health policy, systems and environmental change initiatives to protect and improve maternal, child and family health, including those designed to promote health equity.

Prepare for Future Data Needs

- k. Fulfill future data needs using multiple methods and sources for data collection, analysis and presentation using evolving technology with near real-time data displayed using visualization tools and GIS to meet user's requests.
- l. Develop and adapt data systems as needed.

2. Identify local maternal, child, and family health community assets, develop a prioritized prevention plan using life course expertise and an understanding of health inequities, seek resources and advocate for high priority policy initiatives.

- a. Identify, disseminate and promote emerging and evidence-based information about interventions in the preconception, pregnancy and early childhood periods that optimize lifelong health and social-emotional development.
- b. Make training opportunities available in social determinants of health and the health impact of prenatal and early childhood experiences.
- c. Identify and promote the use of innovative strategies related to childhood adversity and interventions based on evidence-based or promising practices.
- d. Provide subject matter **expertise** to inform policy, systems and environmental change, program design, and communications to decision makers, providers, the public and stakeholders about maternal, child and family health risks and protective factors.
- e. Identify, develop, engage and maintain local strategic partnerships with health systems and social service systems, schools, child care centers, businesses, neighborhoods, parents, caregivers and others to strengthen and support families and reduce sources of child and family stress.
- f. Identify, develop, engage and maintain strategic partnerships with statewide organizations, associations and government agencies to address adverse impacts to mothers, children and families.
- g. Identify, develop, engage, and maintain relationships with academic institutions and/or research centers to advance evidence-based practice and innovation.
- h. Engage and support diverse community members and other partners to develop and implement prioritized plans for addressing important maternal, child and family health risks, taking into consideration the impact of social and physical environments on health and well-being.

- i. Work with partners to advocate for high priority policy, system, and environmental change initiatives regarding maternal and child health and seek funding to implement evidence-based or innovative prevention initiatives.

3. Assure mandated newborn screening done by the state public health lab to test every infant born in Washington to detect and prevent the developmental impairments and life-threatening illnesses associated with congenital disorders that are specified by the State Board of Health. (Centralized activity – currently provided by DOH)

- a. Screen all babies born in Washington according to the State Board of Health (SBOH) Newborn screening regulations and state law.
- b. Notify physicians when abnormal tests results are found.
- c. Provide technical assistance to health care providers, parents and the public about congenital disorders on the newborn screening panel.
- d. Ensure that positive screens receive further testing and diagnosis, and that diagnosed patients receive referrals into a system of care according to national guidelines.

4. When additional important services are delivered regarding maternal, child and family health, assure that they are well coordinated with foundational services.

- a. Identify and support relationships, interdependencies, and coordination needs between the **foundational program** and related **additional important services (AIS)**.
- b. Leverage **foundational program** activities and funding to support identification and implementation of related **AIS** and vice versa.

K. Access/Linkage with Medical, Oral and Behavioral Health Care Services

The functional definition of this foundational program includes:

1. Provide accurate timely, statewide and locally relevant information statewide and to communities on the medical, oral and behavioral health care system.

Data and Data Systems and Analysis

- a. Collect and maintain data to support public health at the state and local level (e.g. Health Professional Shortage Areas [HPSA] and other data).
- b. Access, analyze, interpret and share data about health care, including disaggregating data to identify inequities.
- c. Collect and maintain health care provider and facility licensing, inspection and enforcement data to support public health at the state level.
- d. Develop and implement protocols for data and information sharing between public health, health care providers, health care systems, Tribal Nations, other local, state, and federal agencies and the public. Include protocols for confidentiality as appropriate.
- e. As appropriate, prepare data files to share and make available to researchers and other stakeholders.

Reporting, Communications, and Policy

- f. Produce and share periodic/routine reports of health care access and regulation of health care providers and facilities.
- g. Inform decision makers of potential and actual impacts to the health of the public based on data and published reports.
- h. Provide the public, regulated facilities and stakeholder organizations with effective and timely communication of recommendations for medical, oral and behavioral health care and ensuring public safety.
- i. Use data and evidence-based practices to facilitate development of public health policy, systems and environmental change initiatives for medical, oral and behavioral health care and public safe, including those designed to promote health equity.

Prepare for Future Data Needs

- j. Fulfill future data needs using multiple methods and sources for data collection, analysis and presentation using evolving technology with near real-time data displayed using visualization tools and GIS to meet user's requests.
- k. Ability to develop and adapt data systems as needed.

2. Participate actively in local, regional and state level collaborative efforts regarding medical, oral and behavioral systems planning to improve health care quality and effectiveness, reduce health care costs and improve population health.

- a. Continuously work with local and state partners to improve health care quality and effectiveness, reduce health care costs and improve population health. Identify evidence-based interventions and promising practices for population health, especially those that are upstream and preventative. Share information with partners and the public on these interventions.
- b. Collaborate with partners in finding funding for these interventions.
- c. Evaluate progress on health care quality and effectiveness, reduction of health care costs and improving population health at the state and local level every three to five years. Use findings to improve intervention strategies with partners.
- d. In concert with local, state and national health care providers and groups, develop and implement prioritized plans for assuring access to specific clinical services of public health importance, such as family planning, key services for pregnant women and their infants (e.g. maternity support and Women, Infants, and Children [WIC]) and sexually transmitted disease (STD) and Human Immunodeficiency Virus (HIV) testing and treatment; appropriate follow-up for positive newborn screening test (e.g. referrals to the Children with Special Health Care Needs [CSHCN] program) and positive blood lead levels; seek resources and advocate for high priority policy initiatives.
- e. Provide subject matter **expertise** to inform policy, systems and environmental change, program design, and communications to decision makers, providers, the public and stakeholders about relevant public health risks. This includes building understanding of social determinants of health, risk and protective factors and the value of prevention and early upstream intervention to improve population health and reduce costs.
- f. Identify, develop, engage and maintain local strategic partnerships with health and behavioral health systems, community groups, social services, criminal justice, education system and others to increase access to services of public health importance.¹²

¹² Within K.2., clinical services of public health importance include family planning, key services for pregnant women and their infants (e.g. maternity support and Women, Infants, and Children [WIC]) and sexually transmitted disease (STD) and Human Immunodeficiency Virus (HIV) testing and treatment; appropriate follow-up for positive newborn screening test (e.g. referrals to the Children with Special Health Care Needs [CSHCN] program) and positive blood lead levels; seek resources and advocate for high priority policy initiatives.

- g. Identify, develop, engage and maintain strategic partnerships with statewide organizations, associations and government agencies to increase access services of public health importance.¹³
- h. Work with partners to develop a prioritized plan addressing increased access to high priority public health services.¹³
- i. Work with partners to advocate for high priority policy, system, and environmental change initiatives regarding access to high priority public health services¹³ and seek funding to implement evidence-based or innovative prevention and disease control initiatives considered **FPHS**.
- j. Identify, develop, engage and maintain relationships with academic institutions and/or research centers to advance evidence-based practice and innovation.
- k. Work with local health care systems to address health care shortages and emergent health care gaps.

3. Improve patient safety through inspection and licensing of health care facilities and licensing, monitoring and discipline of health care providers. (Centralized activity – currently provided by DOH)

- a. Develop health care provider and facility public health regulations per local, state and federal mandates.
- b. Develop and implement policies and procedures for regulated facility inspections.
- c. Enforce health care provider and facility public health regulations including licensing, inspection and enforcement actions.
- d. Conduct or assist with investigations that have a patient safety, communicable disease or other health risk component.
- e. Conduct timely investigation of complaints related to mandated public health programs.
- f. Develop action plans for health care facility emergencies.
- g. Maintain and implement protocols and systems to ensure confidentiality throughout inspection, investigation, reporting and maintenance of data.
- h. Provide consultation and technical assistance to other local and state agencies and the general public.

¹³ Within K.2., clinical services of public health importance include family planning, key services for pregnant women and their infants (e.g. maternity support and Women, Infants, and Children [WIC]) and sexually transmitted disease (STD) and Human Immunodeficiency Virus (HIV) testing and treatment; appropriate follow-up for positive newborn screening test (e.g. referrals to the Children with Special Health Care Needs [CSHCN] program) and positive blood lead levels; seek resources and advocate for high priority policy initiatives.

- i. Coordinate public health efforts with Tribal Nations and local, state and federal partners.
- j. Evaluate implementation of patient safety regulations and use findings to improve processes and procedures.

4. When additional important services are delivered regarding medical, oral and behavioral health, assure that they are well coordinated with foundational services.

- a. Identify and support relationships, interdependencies, and coordination needs between the **foundational program** and related **additional important services (AIS)**.
- b. Leverage **foundational program** activities and funding to support identification and implementation of related **AIS** and vice versa.

L. Vital Records

The functional definition of this foundational program includes:

1. In compliance with state law and in concert with local, state and national groups, assure a system of vital records. (Centralized activity – currently provided by DOH)

- a. Develop and implement statewide policies, regulations and law on vital records, including adequate standards for security, fraud prevention and proper records identification.
- b. Develop and maintain secure information technology systems, used by the Washington State Department of Health (DOH) and Local Health Jurisdictions (LHJs), for registering vital records, permanently storing the records and issuing copies.
- c. Maintain systems for state and federal agencies to electronically access Washington's vital records for public benefit eligibility verification and termination, establishment of social security numbers, child support enforcement, and other purposes.
- d. Manually enter reports of vital events filed on paper.
- e. Perform amendments and corrections to information on vital records.
- f. Provide guidance and training to individuals responsible for vital records registration including LHJ deputy registrars, medical examiners, coroners, funeral directors, physicians, midwives, hospital birth clerks, county auditors and county court clerks.
- g. Perform quality checks, edits and coding of the data collected on vital records.
- h. Electronically exchange vital records with other states, submit data to the Centers for Disease Control (CDC) National Vital Statistics System and provide records to other authorized data partners.
- i. Produce and securely release vital statistics data for public health assessment, evaluation and research in a timely manner.

2. Provide certified birth and death certificates in compliance with state law and rule.

- a. Register records of births and deaths that occur in the local jurisdiction, using the state's Washington Health and Life Event System (WHALES) and the Electronic Death Registration System (EDRS). Review records for compliance with state laws, rules and policies.
- b. Issue certified copies of birth and death records for events that occurred in any Washington jurisdiction using the state vital records system.
- c. Perform electronic verification and/or certification of vital events.

Appendix A: Functional Definitions Development Process

The Washington **Foundational Public Health Services (FPHS)** framework was first defined by the **FPHS** Technical Workgroup in 2012, then revised by the 2014 **FPHS** Policy Workgroup, and was most recently published as **FPHS** Definitions V1.2 in March 2016.¹⁴ The original definitions simply included three to seven **elements** under each **foundational capability and program** which described the foundational work.

However, for the **governmental public health system** to successfully and consistently implement **FPHS**, more detail was needed in the definitions. In 2017, the **FPHS** Technical Workgroup oversaw the development of **functional definitions** that:

- Describe “what” **FPHS** provides for Washington’s communities, but not “how” the **governmental public health system** should provide it,
- Are agnostic to which governmental public health provider should provide it,
- Are reduced to discreet activities (define as few actions as possible per statement) and begin with the verb identifying the action to be taken, and
- Align with existing guidelines and regulations.

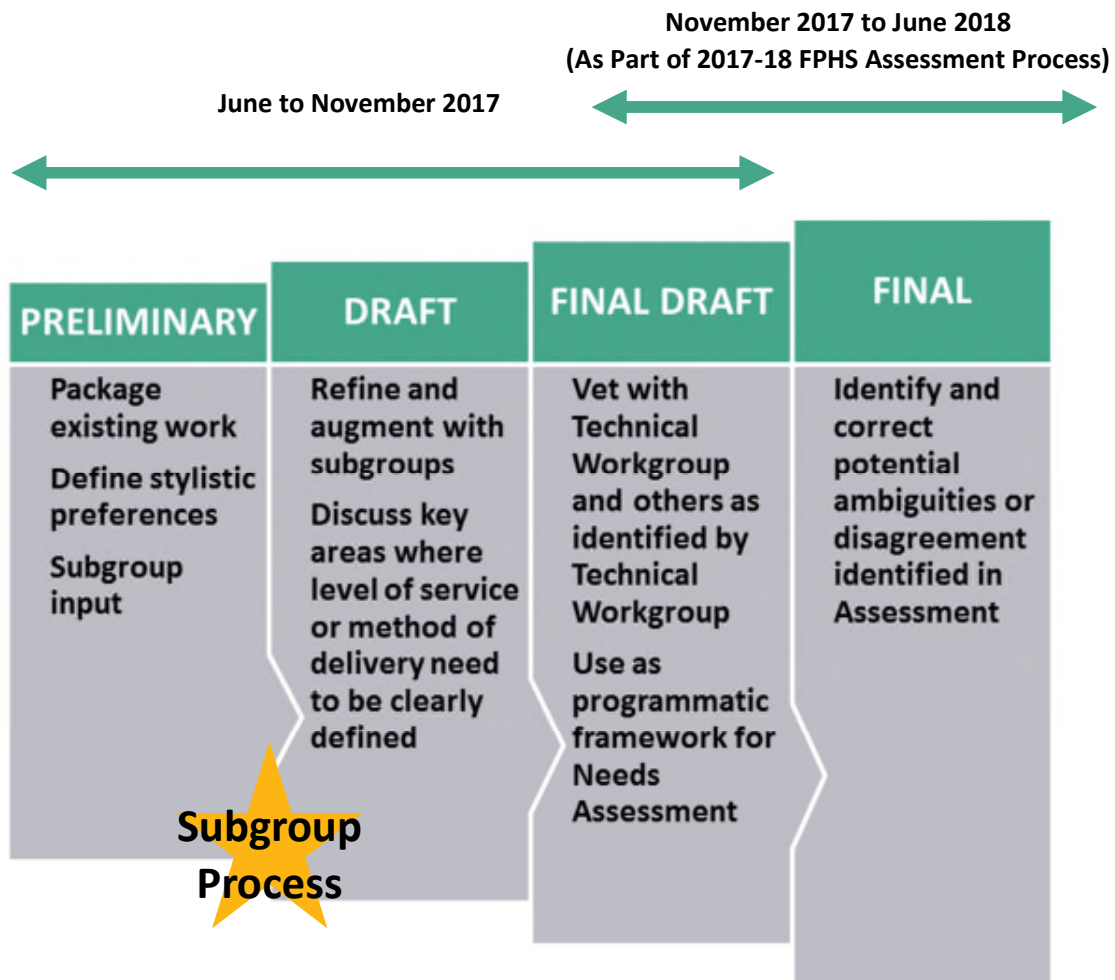
These **functional definitions** add detail by establishing **activities** under the **elements** for each **foundational capability and program**.

As part of the **functional definitions** development process, some revisions were made to **FPHS** Definitions V1.2, March 2016 and approved by both the **FPHS** Technical Workgroup and Steering Committee.

The **FPHS** Technical Workgroup formed subgroups comprised of **governmental public health system** subject matter experts to provide input on preliminary draft chapters for each of the **foundational capabilities and programs** in a three-step iterative process (See *Acknowledgements* for the list of subgroup members). Their work as part of a broader **functional definitions** development process, illustrated in Exhibit 2.

¹⁴ FPHS Definitions V1.2, March 2016: <https://www.doh.wa.gov/Portals/1/Documents/1200/FPHSp-2016definitions.pdf>.

Exhibit 2: Functional Definitions Development Process



Source: BERK Consulting, 2017.

As part of this iterative process, a series of draft functional definition manuals were developed, including:

- **Preliminary Draft 1.0.** Initial version of the **functional definitions** based on packaging of existing work, resources, and products.
- **Preliminary Draft 2.0.** First iteration developed by subgroup, incorporating their input from the first round of edits.
- **Preliminary Draft 3.0.** Second iteration developed by subgroup, incorporating their input from the second round of edits.
- **Draft.** Third iteration developed by subgroup, incorporating their input from the third round of edits. This version was vetted by the **governmental public health system**, including the Technical Workgroup.
- **Final Draft.** Final vetted version which is documented in this manual and will be used as the programmatic framework of the statewide **FPHS** Assessment.

The **functional definitions** published in this document (considered to be Version 1.3), the final draft *Foundational Public Health Services Functional Definitions Manual*. As shown in Exhibit 2, it is expected that these final draft **functional definitions** will be refined into a final version following completion of the 2017-18 FPHS Assessment in June 2018.

Beyond development of the final *Foundational Public Health Services Functional Definitions Manual*, it is expected that these definitions will continue to evolve alongside the public health practice. A process will be established for periodic updates to the **FPHS** definitions, and *Foundational Public Health Services Functional Definitions Manual*.

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Appendix B: Crosswalk to PHAB Accreditation Standards

This crosswalk shows how the FPHS Functional Definitions (at the element-level) align to Public Health Accreditation Board (PHAB) Accreditation Standards (Version 1.5), which describe how public health as a practice “improves and protects the health of every community by advancing the quality and performance of public health departments”.

PHAB Accreditation Standards		WA FPHS Functional Definitions Elements
Domain 1: Conduct and disseminate assessments focused on population health status and public health issues facing the community.		
Standard 1.1	Participate in or lead a collaborative process resulting in a comprehensive community health assessment.	<ul style="list-style-type: none"> Assessment (Surveillance and Epidemiology), Element 3 (A.3.)
Standard 1.2	Collect and maintain reliable, comparable and valid data that provide information on conditions of public health importance and on the health status of the population.	<ul style="list-style-type: none"> Assessment (Surveillance and Epidemiology), Element 1 (A.1.)
Standard 1.3	Analyze public health data to identify trends in health problems, environmental public health hazards and social and economic factors that affect the public’s health.	<ul style="list-style-type: none"> Assessment (Surveillance and Epidemiology), Element 2 (A.2.) Prevention and Control of Communicable Disease and Other Notifiable Conditions, Element 1 (G.1.) Chronic Disease, Injury and Violence Prevention, Element 1 (H.1.) Environmental Public Health, Element 1 (I.1.) Maternal/Child/Family Health, Element 1 (J.1.)

PHAB Accreditation Standards		WA FPHS Functional Definitions Elements
Standard 1.4	Provide and use the results of health data analysis to develop recommendations regarding public health policies, processes, programs or interventions.	<ul style="list-style-type: none"> • Policy Development and Support, Element 1 (D.1.) • Prevention and Control of Communicable Disease and Other Notifiable Conditions, Element 1 (G.1.) • Chronic Disease, Injury and Violence Prevention, Element 1 (H.1.) • Environmental Public Health, Element 1 (I.1.) • Maternal/Child/Family Health, Element 1 (J.1.)
Domain 2: Investigate health problems and environmental public health hazards to protect the community.		
Standard 2.1	Conduct timely investigations of health problems and environmental public health hazards.	<ul style="list-style-type: none"> • Environmental Public Health, Element 3 (I.3.)
Standard 2.2	Contain/mitigate health problems and environmental public health hazards.	<ul style="list-style-type: none"> • Environmental Public Health, Element 3 (I.3.) • Environmental Public Health, Element 4 (I.4.) • Environmental Public Health, Element 5 (I.5.)
Standard 2.3	Ensure access to laboratory and epidemiological/environmental public health expertise and capacity to investigate and contain/mitigate public health problems and environmental public health hazards.	<ul style="list-style-type: none"> • Prevention and Control of Communicable Disease and Other Notifiable Conditions, Element 5 (G.5.) • Environmental Public Health, Element 3 (I.3.)
Standard 2.4	Maintain a plan with policies and procedures for urgent and non-urgent communications.	<ul style="list-style-type: none"> • Emergency Preparedness (All Hazards), Element 4 (B.4.) • Communication, Element 2 (C.2.)

PHAB Accreditation Standards		WA FPHS Functional Definitions Elements
Domain 3: Inform and educate about public health issues and functions.		
Standard 3.1	Provide health education and health promotion policies, programs, processes and interventions to support prevention and wellness.	<ul style="list-style-type: none"> • Policy Development and Support, Element 1 (D.1.) • Chronic Disease, Injury and Violence Prevention, Element 3 (H.3.)
Standard 3.2	Provide information on public health issues and public health functions through multiple methods to a variety of audiences.	<ul style="list-style-type: none"> • Communication, Element 2 (C.2.) • Prevention and Control of Communicable Disease and Other Notifiable Conditions, Element 1 (G.1.) • Chronic Disease, Injury and Violence Prevention, Element 1 (H.1.) • Environmental Public Health, Element 1 (I.1.) • Maternal/Child/Family Health, Element 1 (J.1.) • Access/Linkage with Medical, Oral and Behavioral Health Care Services, Element 1 (K.1.)
Domain 4: Engage with the community to identify and address health problems.		
Standard 4.1	Engage with the public health system and the community in identifying and addressing health problems through collaborative processes.	<ul style="list-style-type: none"> • Community Partnership Development, Element 1 (E.1.)

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PHAB Accreditation Standards		WA FPHS Functional Definitions Elements
Standard 4.2	Promote the community's understanding of and support for policies and strategies that will improve the public's health.	<ul style="list-style-type: none"> • Community Partnership Development, Element 1 (E.1.) • Prevention and Control of Communicable Disease and Other Notifiable Conditions, Element 2 (G.2.) • Chronic Disease, Injury and Violence Prevention, Element 2 (H.2.) • Environmental Public Health, Element 2 (I.2.) • Maternal/Child/Family Health, Element 2 (J.2.) • Access/Linkage with Medical, Oral and Behavioral Health Care Services, Element 2 (K.2.)
Domain 5: Develop public health policies and plans.		
Standard 5.1	Serve as a primary and expert resource for establishing and maintaining public health policies, practices, and capacity.	<ul style="list-style-type: none"> • Community Partnership Development, Element 1 (E.1.)
Standard 5.2	Conduct a comprehensive planning process resulting in a Tribal/state/community health improvement plan.	<ul style="list-style-type: none"> • Assessment (Surveillance and Epidemiology), Element 3 (A.3.)
Standard 5.3	Develop and implement a health department organizational strategic plan.	<ul style="list-style-type: none"> • Business Competencies, Element 1 (F.1)
Standard 5.4	Maintain an all hazards emergency operations plan.	<ul style="list-style-type: none"> • Emergency Preparedness (All Hazards), Element 1 (B.1.)
Domain 6: Enforce public health laws.		
Standard 6.1	Review existing laws and work with governing entities and elected/appointed officials to update as needed.	<ul style="list-style-type: none"> • Policy Development and Support, Element 2 (D.2.)

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Appendix B: Crosswalk to PHAB Accreditation Standards

PHAB Accreditation Standards		WA FPHS Functional Definitions Elements
Standard 6.2	Educate individuals and organizations on the meaning, purpose and benefit of public health laws and how to comply.	<ul style="list-style-type: none"> • Community Partnership Development, Element 1 (E.1.) • Prevention and Control of Communicable Disease and Other Notifiable Conditions, Element 2 (G.2.) • Chronic Disease, Injury and Violence Prevention, Element 2 (H.2.) • Environmental Public Health, Element 2 (I.2.) • Maternal/Child/Family Health, Element 2 (J.2.) • Access/Linkage with Medical, Oral and Behavioral Health Care Services, Element 2 (K.2.)
Standard 6.3	Conduct and monitor public health enforcement activities and coordinate notification of violations among appropriate agencies.	<ul style="list-style-type: none"> • Prevention and Control of Communicable Disease and Other Notifiable Conditions, Element 4 (G.4.) • Environmental Public Health, Element 4 (I.3.) • Environmental Public Health, Element 4 (I.4.) • Environmental Public Health, Element 5 (I.5.) • Access/Linkage with Medical, Oral and Behavioral Health Care Services, Element 3 (K.3.)
Domain 7: Promote strategies to improve access to health care.		
Standard 7.1	Assess health care service capacity and access to health care services.	<ul style="list-style-type: none"> • Assessment (Surveillance and Epidemiology), Element 2 (A.2.) • Access/Linkage with Medical, Oral and Behavioral Health Care Services, Element 1 (K.1.) • Access/Linkage with Medical, Oral and Behavioral Health Care Services, Element 2 (K.2.)

Washington Foundational Public Health Services Functional Definitions Manual
Appendix B: Crosswalk to PHAB Accreditation Standards

PHAB Accreditation Standards		WA FPHS Functional Definitions Elements
Standard 7.2	Identify and implement strategies to improve access to health care services.	<ul style="list-style-type: none"> • Access/Linkage with Medical, Oral and Behavioral Health Care Services, Element 2 (K.2.) • Access/Linkage with Medical, Oral and Behavioral Health Care Services, Element 4 (K.4.)
Domain 8: Maintain a competent public health workforce.		
Standard 8.1	Encourage the development of a sufficient number of qualified public health workers.	<ul style="list-style-type: none"> • Business Competencies, Element 5 (F.5.)
Standard 8.2	Ensure a competent workforce through the assessment of staff competencies, the provision of individual training and professional development, and the provision of a supportive work environment.	<ul style="list-style-type: none"> • Business Competencies, Element 5 (F.5.)
Domain 9: Evaluate and continuously improve health department processes, programs and interventions.		
Standard 9.1	Use a performance management system to monitor achievement of organizational objectives.	<ul style="list-style-type: none"> • Business Competencies, Element 2 (F.2.)
Standard 9.2	Develop and implement quality improvement processes integrated into organizational practice, processes and interventions.	<ul style="list-style-type: none"> • Business Competencies, Element 3 (F.3.)
Domain 10: Contribute to and apply the evidence base of public health.		
Standard 10.1	Identify and use the best available evidence for making informed public health practice decisions.	<ul style="list-style-type: none"> • Policy Development and Support, Element 1 (D.1.)
Standard 10.2	Promote understanding and use of the current body of research results, evaluations and evidence-based practices with appropriate audiences.	<ul style="list-style-type: none"> • Policy Development and Support, Element 1 (D.1.)
Domain 11: Maintain administrative and management capacity.		

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Appendix B: Crosswalk to PHAB Accreditation Standards

PHAB Accreditation Standards		WA FPHS Functional Definitions Elements
Standard 11.1	Develop and maintain an operational infrastructure to support the performance of public health functions.	<ul style="list-style-type: none"> • Business Competencies, Element 4 (F.4.) • Business Competencies, Element 7 (F.7.)
Standard 11.2	Establish an effective financial management system.	<ul style="list-style-type: none"> • Business Competencies, Element 6 (F.6.)
Domain 12: Maintain capacity to engage the public health governing entity.		
Standard 12.1	Maintain current operational definitions and statements of the public health roles, responsibilities and authorities.	<ul style="list-style-type: none"> • Community Partnership Development, Element 2 (E.2.) • Business Competencies, Element 1 (F.1.)
Standard 12.2	Provide information to the governing entity regarding public health and the official responsibilities of the health department and of the governing entity.	<ul style="list-style-type: none"> • Business Competencies, Element 1 (F.1.)
Standard 12.3	Encourage the governing entity's engagement in the public health department's overall obligations and responsibilities.	<ul style="list-style-type: none"> • Business Competencies, Element 1 (F.1.)

Appendix C: Acronyms

AAR	After Action Reports
ACE	Adverse Childhood Events
BRFSS	Behavioral Risk Factor Surveillance System
CBO	Community-based Organizations
CDC	Centers for Disease Control
CEMP	Comprehensive Emergency Management Plan
CHA	Community Health Assessment
CHARS	Comprehensive Hospital Abstract Reporting System
CHAT	Community Health Assessment Tool
CHIP	Community Health Improvement Plan
COOP	Continuity of Operations Plan
DOH	Washington State Department of Health
EDRS	Electronic Death Registration System
EMS	Emergency Medical Services
EOC	Emergency Operations Center
EPA	United States Environmental Protection Agency
ESF8	Emergency Support Function 8 – Public Health & Medical
FDA	United States Food and Drug Administration
FPHS	Foundational Public Health Services
GAAP	Generally Accepted Accounting Principles
GASB	Governmental Accounting Standards Board
GIS	Geographic Information Systems
HIV	Human Immunodeficiency Virus
HPSA	Health Professional Shortage Area
HYS	Healthy Youth Survey
IOM	Institute of Medicine

IIS	Immunization Information System
LHJ	Local Health Jurisdiction
MERS	Middle East Respiratory Syndrome
PHAB	Public Health Accreditation Board
PHNCI	Public Health National Center for Innovations
PHRED	Public Health Reporting of Electronic Data
PRAMS	Pregnancy Risk Assessment Monitoring System
RCW	Revised Code of Washington
RHINO	Rapid Health Information NetwOrk
SARS	Severe Acute Respiratory Syndrome
SHA	State Health Assessment
SHIP	State Health Improvement Plan
STD	Sexually Transmitted Disease
TB	Tuberculosis
USDA	United States Department of Agriculture
WAC	Washington Administrative Code
WDRS	Washington Disease Reporting System
WELRS	Washington Electronic Lab Reporting System
WHALES	Washington Health and Life Event System

Appendix D: Glossary

24/7 Access: Each governmental public health authority as well as a few specific DOH programs must be reachable by phone 24/7 for urgent or emergency issues. It is expected that use of the 24/7 agency or program contact numbers will reach, within 15 minutes, a knowledgeable public health professional capable of assessing an event or urgent public health consequence and initiating an appropriate response.

Ability to: Capacity and expertise to implement an activity, element and/or foundational capability or program, as needed.

Activities: Components of the definitions that further describe the work of the governmental public health system in implementing elements. There are 350 activities which are intended to be as discreet as possible, defining as few actions as possible per statement) and begin with a verb identifying the action to be taken. They are denoted by lowercase lettered and individually assigned to one Element, which are also individually assigned to one foundational capability or program, such that they are represented as “[Foundational Capability Uppercase Letter].[Element Number].[Activity Lowercase Letter].”

Additional Important Services (AIS): These are services that are critical locally and do not necessarily need to be provided by governmental public health statewide because they are a shared responsibility of local, state and federal governmental public health and other partners.

Assure¹⁵: The dictionary definitions implies the removal of doubt and suspense from a person's mind In the context of the FPHS definitions, this means that it is foundational for the governmental public health system to invest time and resources as needed to make sure that the service is available to the community, generally as provided by partner organizations. The service may already be provided by a partner organization or governmental public health may coordinate with partners to get them to provide the service. If no other organization is willing or able to provide the service, governmental public health may decide to become the provider of the services and seek the necessary funds for the service.

Capacity: Staff with the necessary expertise and associated resources to provide the activity, element and/or foundational capability or program.

Community Health Assessment (CHA): An assessment of community health. A CHA should be conducted every three to five years in conjunction with community partners that:

¹⁵ PHAB definition of “Assurance”: “The process of determining that “services necessary to achieve agreed upon goals are provided, either by encouraging actions by other entities (public or private sector), by requiring such action through regulation, or by providing services directly.” (Institute of Medicine, *The Future of Public Health*. Washington, DC: National Academy Press; 1988.)”

http://www.phaboard.org/wp-content/uploads/FINAL_PHAB-Acronyms-and-Glossary-of-Terms-Version-1.5.pdf.

- Uses data and information from a variety of sources, including qualitative and quantitative data,
- Describes the data and information used,
- Describes demographics of the population,
- Describes community health issues including identification of significant health issues and populations experiencing health inequities,
- Describes the factors that contribute to the significant health issues and health inequities,
- Describes assets or resources available to address priority health issues,
- Review the CHA and current data in conjunction with community partners and update the assessment every three to five years, and
- Ensure community health assessments are accessible to agencies, organizations, other stakeholders, and the general public.

Community Health Improvement Plan (CHIP): A plan for improving community health. A CHIP should be developed in conjunction with the governmental public health system and other community partners and:

- Uses information from the CHA to assist in the identification of community health issues,
- Prioritizes community health issues for action,
- Lead or engage with and document the collaborative health improvement planning process, with a wide range of community partners representing the many sectors of the community, and actions or strategies taken in partnership with others towards implementation,
- Describes assets or resources available to address priority health issues,
- Establishes a plan of action to address priority health issues, that includes goals, targets and performance measures and evidence-based interventions or innovative practices and designates individuals and organizations that have accepted responsibility for implementing strategies outlined in the plan,"
- Describes the desired outcomes and how progress will be measured,
- Describes policy changes needed to accomplish the identified health objectives,
- Align and coordinate with community partner needs assessment, region, Accountability Community of Health, state and national priorities to the extent possible,
- Review progress on the CHIP, review the CHA, and revise priority health issues if needed in conjunction with community partners and update the action plan every three to five years, and
- Document areas of the plan that were implemented by the LHJ.

Comprehensive Emergency Management Plan (CEMP): Provides a policy-level framework to support emergency response activities, by describing specific roles, responsibilities, functions, and support relationships of the agency. The CEMP also provides a framework for jurisdictional

coordination and cooperation supporting response and recovery in times of emergencies and disasters.

Element: Components of the definitions that further describe the work of the governmental public health system in implementing foundational capabilities and programs. There are 48 Elements which are Numbered and individually assigned to one foundational capability or program, such that they are represented as “[Foundational Capability Uppercase Letter].[Element Number].”

Emergency Communication Plan: A plan providing guidance on how to communicate in an emergency. This plan should address:

- A process for identifying a public information officer, message development, approval and release of urgent communications,
- 24/7 contact information for health care providers, response partners, media (including non-English media sources) and other partners and stakeholders,
- Templates for holding statements, news releases, talking points for use when communicating about public health threats and emergencies,
- Processes for leading, coordinating, or participating in public information planning, including working in a Joint Information Center or System during a local/regional/state emergency impacting the public’s health,
- Processes and templates that support risk communication principles to maintain trust and credibility in an emergency or public health threat,
- Processes and community contacts for delivering critical health information to harder to reach communities, including limited English proficient residents and those with access and functional needs, and
- A process for notifying local/state public health partners in advance of issuing news releases, or social media messages which may impact their jurisdictions.

Emergency Support Function (ESF8) Public Health and Medical Services Annex: Provides the mechanism for coordinated federal assistance to supplement local, state, and Tribal Nations’ resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated federal response, and/or during a developing potential health and medical emergency.

Ensure: The dictionary definition implies a virtual guarantee. In the context of the FPHS definitions, this means that the governmental public health system provides the service to the community.

Expertise: The appropriate knowledge and skills necessary to provide the activity, element and/or foundational capability or program.

Foundational Capabilities: The crosscutting capacity and expertise needed to support public health programs.

Foundational Programs: The subset of services in each public health program area that are defined as foundational.

Foundational Public Health Services (FPHS): A limited statewide set of core public health services that include foundational capabilities and programs that (1) must be available to all people in Washington, and (2) meet one or more of the following criteria:

- Services for which governmental public health is the only or primary provider of the service statewide,
- Population-based services (versus individual services) that are focused on prevention, and
- Services that are mandated by federal or state laws.

Functional Definition: Definitions that describe “what” FPHS provides for Washington’s communities, but not “how” governmental public health should provide it,

- Are agnostic to which governmental public health provider should provide it,
- Are reduced to discreet activities (define as few actions as possible per statement) and begin with a verb identifying the action to be taken, and
- Align with existing guidelines and regulations.

Media Relations Plan: A plan for engaging, interacting with, and maintaining relationships with media. This Plan should include:

- How to draft, approve and distribute key message content,
- Which media method to use,
- How to track broadcast, digital, and social media coverage,
- How to maintain media access to an agency contact after business hours and on weekends, and
- What modifications to make to the plan and policies in an emergency.

Notifiable Conditions: Selected diseases and conditions for which Washington State health care providers, health care facilities, laboratories, veterinarians, food service establishments, child day care facilities and schools are legally required to notify public health authorities at their local health jurisdiction (LHJ) of suspected or confirmed cases. The full current list of notifiable conditions is available here:

<https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/NotifiableConditions>.

Public Health Accreditation Standards: A set of standards defined by the Public Health Accreditation Board (PHAB) to support assessment of the quality and performance of all public health authorities in the United States. Authorities that meet these standards through a vetting process with PHAB can become accredited.

Public Health Response Plan: A jurisdiction-specific plan outlining public health response in the case of an emergency. This may be part of a jurisdiction’s Comprehensive Emergency Management Plan (CEMP) Emergency Support Function (ESF) 8 Public Health and Medical Services Annex

- Protocols that describe the assessment of emergency situations, management of incidents and mobilization of response activities,

- Criteria and procedures for activating the jurisdiction's public health response for all hazards, including communicable disease outbreaks, environmental public health hazards, natural and technological disasters,
- The process for identifying and activating support personnel (agency staff and outside personnel) who will be called upon to provide **surge capacity** during an incident response,
- How the Incident Command System is used to manage public health incidents, and to support policy-level decision making,
- The process for notifying and mobilizing public health staff during an incident,
- Provisions for protecting the health of vulnerable populations from the consequences of public health incidents, and
- The process for updating the plan based on lessons learned from real-life events and exercises.

Quality Improvement: The use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It is a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.

Recreational Water: Water recreation facilities specified in Washington Administrative Code (WAC) and natural beaches.

Strategic Policy Agenda: A policy agenda that includes specific strategies to improve public health at the system level. The agenda should contain strategic policy priorities and goals and should align with other plans (e.g. Community or State Health Improvement Plan [CHIP or SHIP] and/or strategic plan) but can also include policy goals not related to other plans, as appropriate.

State Health Assessment (SHA): An assessment of statewide health. A SHA should be conducted every three to five years in conjunction with the governmental public health system and other statewide partners that:

- Uses data and information from a variety of sources, including qualitative and quantitative data,
- Describes the data and information used,
- Describes demographics of the population,
- Describes statewide health issues including identification of significant health issues and populations experiencing health inequities,
- Describes the factors that contribute to the significant health issues and health inequities,
- Describes assets or resources available to address priority health issues,
- Review the SHA and current data in conjunction with the governmental public health system and other statewide partners and update the assessment every three to five years. Ensure

that local community members at large review and contribute to the assessment, including those in populations where health inequities exist,” and

- Ensure state, regional and community health assessments are accessible to agencies, organizations, other stakeholders, and the general public.

State Health Improvement Plan (SHIP): A plan for improving statewide health. A SHIP should be developed in conjunction with the governmental public health system and other statewide partners and:

- Uses information from the SHA to assist in the identification of statewide health issues,
- Prioritizes state health issues for action,
- Lead or engage with and document the collaborative health improvement planning process, participation of stakeholders, and actions or strategies taken in partnership with others towards implementation,
- Describes assets or resources available to address priority health issues,
- Establishes a plan of action to address priority health issues, that includes goals, targets and performance measures and evidence-based interventions or innovative practices,
- Describes the desired outcomes and how progress will be measured,
- Align and coordinate with national priorities and needs assessments and those of the state-level governmental public health system, other state agencies, statewide partners to the extent possible, and
- Review progress on the SHIP, review the SHA, and revise priority health issues if needed in conjunction with the governmental public health system and other statewide partners and update the action plan every three to five years.

Surge Capacity: The staffing and resources necessary to provide the implement the activity, element and/or foundational capability or program in annually-expected (one year) events that lead to demand increases.

Washington Governmental Public Health System: All governmental public health authorities, which currently include the Washington State Department of Health (DOH), Washington State Board of Health (SBOH), 35 local health jurisdictions (LHJ) and Tribal Nations.

Written procedures for Emergency Support Function 8 – Public Health & Medical (ESF8): These procedures should be published in the State or County Comprehensive Emergency Management Plan (CEMP), and/or the Public Health Response Plan, and should include a description of:

- Protocols that describe the assessment of emergency situations, management of incidents, and mobilization of response activities,
- Criteria and procedures for activating the jurisdiction’s public health and medical response for all hazards, including communicable disease outbreaks, environmental public health hazards, natural, and technological disasters,
- The process for identifying and activating support personnel (agency staff and outside personnel) who will be called upon to provide surge capacity during an incident response,

- How the Incident Command System is used to manage public health and medical incidents, and to support policy-level decision making,
- The process for notifying and mobilizing public health staff during an incident,
- Provisions for protecting the health of populations at increased risk from the consequences of public health incidents, and
- The process for updating the plan based on lessons learned from real-life events and exercises.

Appendix E: Sources/Resources

Centers for Disease Control and Prevention, State Activities Tracking and Evaluation (STATE) System,
http://nccd.cdc.gov/STATESystem/rdPage.aspx?rdREport=OSH_STATE.Highlights&rdRequestForwarding=Form

Institute of Medicine. *“For the Public’s Health: Investing in a Healthier Future.”* April 10, 2012.

Public Health National Center for Innovations (PHNCI), FPHS Fact Sheet:
http://phnci.org/uploads/resource-files/PHNCI-FPHS-Factsheet_FINAL-1.pdf.

Washington State Department of Health, Foundational Public Health Services (FPHS) Definitions V1.2, March 2016:
<https://www.doh.wa.gov/Portals/1/Documents/1200/FPHSp-2016definitions.pdf>.

Publication Number: DOH 820-073 November 2017

For more information or additional copies of this report:

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Please see Appendix A: Functional Definitions Development Process, Acknowledgements



John Wiesman, DrPH
Secretary of Health

HIV Planning Steering Group (HPSG) January 17 Agenda

Location: Washington State Department of Health; 20425 72nd Ave S, Room 309; Kent, Washington 98032

Date/Time: January 17, 2019; 10:00am – 3:00pm

Estimated Time	Section Topics for Discussion	Section Objective
10:00am – 10:15am	I. Welcome/Housekeeping/Announcements/Introductions (15 minutes) a. Introductions b. Agenda Review with Action c. Minutes with Action d. Overview of LEADERSHIP – Exec Committee	Provide Information Approve Agenda Approve Minutes
10:15am – 10:25am	II. Updates & Discussions (10 minutes) a. Membership Committee – updates, recruitment, volunteers (Scott) b. DOH updates: Legislative and Bree (Tam) c. Legislative update on Co-Pay Accumulator Card (Scott)	Obtain additional members for MC
10:25 am -10:30 am Public Comment (5 minutes)		Receive Public Comment
10:30am – 12:00 pm	III. DOH Presentation & Discussions (1.5 hours) a. Return to Discussion about 70.24 – 30 Minutes– (Tam) b. Discussion of 70.24 with HPSG with Scott and Lauren – 1 hour	
NOTE: Public Comment will be included during each section discussion		Receive Public Comment
12:00pm - 12:30pm (break) Working Lunch		Obtain food (and eat)
12:30pm – 2:50pm	IV. SEW – PHSKC Updates – HIV in PWID – a. Presentation and getting HPSG input on recommendations – ((TBD) – 1 hour b. Hep C Elimination Efforts – Emalie – 30 Minutes V. Programming Updates – Stigma/Prevention/HIV 50+/Latinx Project - Mike/Lydia/Chris/Bryan – 30 Minutes	
NOTE: Public Comment will be included during each section discussion		Receive Public Comment
2:50pm – 2:55pm	VI. HPSG Report Outs / Announcements (5 minutes) a. PEP SEW Announcement and Query – Q2 2019 (Vanessa) b. Any HPSG Member Announcements	Provide Information and Receive HPSG Comments and Suggestions
2:55 pm – 3:00pm Public Comment (5 minutes)		Receive Public Comment
3:00pm	Adjourn	

Opportunities for public comment are provided at the end of each agenda item for comments related to the item and at the end of the meeting for general comments. HPSG Co-Chairs will ask for a show of hands of people who would like to comment. The Public comment time will be divided equally amongst them.

Vaccine Inventory Update

1/17/2019

Last Update	Vaccine	Manufacturer	Brand	NDC Number	Presentation	UPDATE	ACTION	Alternative Products
1/17/2019	Hep B (Adult)	GSK	Engerix-B	58160-0821-52	10 pack - 1 dose syringe	Currently available in both DCs	NONE	NONE
1/16/2019	DTaP-IPV (Pediatric)	GSK	Kinrix	58160-0812-11	10 pack - 1 dose vial	Currently out of inventory in Memphis only	Please cancel all backorders. This product is no longer on the CDC contracts	58160-0812-52
12/3/2018	Hep A (Pediatric)	GSK	Havrix	58160-0825-11	10 pack - 1 dose vial	Currently out of inventory in both DCs	Please cancel all backorders. This product is no longer on the CDC contracts	58160-0825-52
To cancel orders, please contact McKesson: CDCCustomerService@McKesson.com						REMINDER: Based on the information in this table, ExIS awardees may need to update the list of NDCs in their ExIS (e.g., by manual entry into their ExIS or uploading the latest VTrckS federal vaccines list to their ExIS). Contact the Vaccine Order Management Contact Center if you encounter problems with this activity: 1-877-878-6247 or vaccineordermgmt@cdc.gov .		
For vaccine inventory questions, please email: vaccinedistributionc@cdc.gov								

A green row signifies the addition of a product without any inventory issue.

Rows with no color signify a product with a depleted inventory or an inventory issue and alert you that action may need to be taken on your part.

Advance Bulk Purchase Update
Note:

The NDCs listed below are **currently not available** for placing bulk orders on the CDC contracts.
Please contact your Vaccine Advisor for information about alternative products available for bulk order.

58160-0812-11 (PEDIATRIC) GSK Kinrix
 58160-0812-52 (PEDIATRIC) GSK Kinrix
 58160-0815-52 (PEDIATRIC & ADULT) GSK Twinrix
 58160-0818-11 (PEDIATRIC) GSK Hiberix
 58160-0823-11 Zoster (ADULT) GSK Shingrix
 58160-0819-12 Zoster (ADULT) GSK Shingrix
 58160-0820-52 Hep B (PEDIATRIC) GSK Engerix B
 58160-0825-11 (PEDIATRIC) GSK Havrix
 58160-0826-52 Hep A (ADULT) GSK Havrix
 00006-4841-41 Hep A (ADULT) Merck Vaxta
 00006-4096-02 Hep A (ADULT) Merck Vaxta
 00006-4981-00 Hep B (PEDIATRIC) Merck Recombivax HB
 00006-4093-02 Hep B (PEDIATRIC) Merck Recombivax HB
 00006-4094-02 Hep B (ADULT) Merck Recombivax HB
 00006-4995-41 Hep B (ADULT) Merck Recombivax HB

Vaccine Inventory Update

1/16/2019

Last Update	Vaccine	Manufacturer	Brand	NDC Number	Presentation	UPDATE	ACTION	Alternative Products
1/16/2019	Hep B (Adult)	GSK	Engerix-B	58160-0821-52	10 pack - 1 dose syringe	Currently out of inventory in <u>Aurora only</u> Anticipated re-supply 1-2 weeks	Contact McKesson Customer Care if you wish to have your backorders cancelled	58160-0821-11
1/16/2019	DTaP-IPV (Pediatric)	GSK	Kinrix	58160-0812-11	10 pack - 1 dose vial	Currently out of inventory in <u>Memphis only</u>	Please cancel all backorders. This product is no longer on the CDC contracts	58160-0812-52
12/3/2018	Hep A (Pediatric)	GSK	Havrix	58160-0825-11	10 pack - 1 dose vial	Currently out of inventory in <u>both DCs</u>	Please cancel all backorders. This product is no longer on the CDC contracts	58160-0825-52

To cancel orders, please contact McKesson:
CDCCustomerService@McKesson.com

REMINDER: Based on the information in this table, ExIS awardees may need to update the list of NDCs in their

ExIS (e.g., by manual entry into their ExIS or uploading the latest VTrckS federal vaccines list to their ExIS).

For vaccine inventory questions, please email:
vaccinedistributionc@cdc.gov

Contact the Vaccine Order Management Contact Center if you encounter problems with this activity:

1-877-878-6247 or vaccineordermgmt@cdc.gov.

A green row signifies the addition of a product without any inventory issue.

Rows with no color signify a product with a depleted inventory or an inventory issue and alert you that action may need to be taken on your part.

Advance Bulk Purchase Update
Note:

 The NDCs listed below are **currently not available** for placing bulk orders on the CDC contracts.

Please contact your Vaccine Advisor for information about alternative products available for bulk order.

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 58160-0812-52 (PEDIATRIC) GSK Kinrix
 58160-0815-52 (PEDIATRIC & ADULT) GSK Twinrix
 58160-0818-11 (PEDIATRIC) GSK Hiberix
 58160-0823-11 Zoster (ADULT) GSK Shingrix
 58160-0819-12 Zoster (ADULT) GSK Shingrix
 58160-0820-52 Hep B (PEDIATRIC) GSK Engerix B
 58160-0825-11 (PEDIATRIC) GSK Havrix
 58160-0826-52 Hep A (ADULT) GSK Havrix
 00006-4841-41 Hep A (ADULT) Merck Vagta
 00006-4096-02 Hep A (ADULT) Merck Vagta
 00006-4981-00 Hep B (PEDIATRIC) Merck Recombivax HB
 00006-4093-02 Hep B (PEDIATRIC) Merck Recombivax HB
 00006-4094-02 Hep B (ADULT) Merck Recombivax HB
 00006-4995-41 Hep B (ADULT) Merck Recombivax HB

Z Draft STD Statute Modernization

- Defines “**Sexual Transmitted Disease (STD)** of **Special Public Health Significance (PHS)**” as HIV or other infectious diseases determined by the State Board of Health (BOH)
- A new section is added to Chapter 70.24
 - **MISDEAMEANOR**: Maximum of 90 days in jail and up to a \$1,000 fine
 - Unlawful for person w/ a known STD of PHS to have Sexual Intercourse if:
 1. Person counseled by Healthcare provider regarding risk of transmission
 2. Sexual Intercourse was consensual:
 - » Sexual Intercourse is defined in this chapter
 3. Person w/ whom they had Sexual Intercourse is presumed to have transmitted the virus:
 - » Transmission event is grounded in that definition of Sexual Intercourse
 4. Defense to prosecution if person took or attempted to take practical means to avoid transmission
 - **GROSS MISDEAMEANOR**: Penalties of up to one year in jail and fines of up to \$5,000
 - Includes all the above and the Person *knowingly* misrepresents their infection status

Definitions | PROS & CONS

- **STDs of Special PHS:**
 - Definition: HIV and any other disease determined by the State Board of Health by rule (through the WACs), based on generally accepted standards of medical and PH science
 - **PROS:** Changing the WACs have rigorous BOH processes. When seeking to define other Diseases of PHS requires public input. Allows flexibility without the specificity of codifying all infectious diseases.
 - Example HBV, HCV are not included **w/o** BOH rule-making
 - **CONS:** HIV still exceptionalized vs other communicable infections or diseases.
 - Scientifically accurate? *Sexually transmitted disease*" means a bacterial, viral, fungal or parasitic infection, as determined... –
 - » "Infection" might be better than "disease".
 - » Not all infections result in a disease.
 - Example, Chlamydia is very often asymptomatic and not pathogenic in all cases. Consider removing Non-Gonococcal Urethritis (NGU syndrome) as many cases don't have known infectious cause. Other conditions are infections with defined pathogens. NGU is a syndrome, not an infection.
 - What else?

New Section 5 | PROS & CONS

- **MISDEAMEANOR:** Maximum of 90 days in jail and up to a \$1,000 fine
 - Unlawful for person w/ a known STD of PHS to have Sexual Intercourse if:
 - Exposure is eliminated. Another AIDS exceptionalism is removed.
 - Removes the statutory classification of intentional HIV exposure and transmission as a Class A felony (RCW 9A.36.011);
 - Are penalties appropriate? Too much, too little?
 - » What other chronic illness is codified with statutory penalties?
- 1. Person counseled by Healthcare provider regarding risk of transmission
 - Counseling does not specifically call out or convey a categorical understanding about the client's mental acuity
 - What about including language around capacity? Or capacity in understanding the actual risks of transmission? Or informing the client of statutes surrounding their lifelong, chronic illness? Or Treatment as Prev?
 - What else? There needs to be a standard somewhere that gives responsibility to the professional to ascertain that the person counseled understood (language, cognitive issues...)

New Section 5 | PROS & CONS

2. Sexual Intercourse was consensual:

Sexual Intercourse

- Definition: *...ordinary meaning and occurs upon any penetration, however slight, of the vagina or anus of one person by the sexual organs of another whether such persons are of the same or another sex.*
 - Is this definition at face value satisfactory? Does it accomplish our intended goals of modernizing the statute?
 - What are the PROS and CONS of its wording?
 - » **PRO** Codifies Sexual Intercourse as a clinical act and has the appearance of reducing the perception associated with behaviors
 - » **CON:** In seeking define sexual intercourse as a clinical act, it negates long-standing PH safer-sex education and messaging that oral sex or frottage is safer-sex, with less risk behaviors /transmission
 - » **CON:** The definition of sexual intercourse is taken directly from sex offender section of the RCW 9A.44. Used for rape, child molestation, and other sexual misbehavior. Is it appropriate to define Sexual Intercourse for a crime we do not believe is a sex offense on a codified definition of a sexual offense?

» WHAT ELSE?

New Section 5 | PROS & CONS

3. Person w/ whom they had Sexual Intercourse is presumed to have transmitted the virus:

- » Transmission event is grounded in definition of Sexual Intercourse
- » CON: The language *presumed* is not scientifically accurate:
 - Source tracing is not a 1-to-1. Phylogenetic analysis gets us close. It presumes something that cannot be proven, actual transmission.
 - Many variables regarding the partner's or partners' testing history, motivation, and actual knowledge of accused status.
- » Are there PROS to that vagueness?

New Section 5 | PROS & CONS

- 4. Defense to prosecution if person took or attempted to take practical means to avoid transmission
- **Definition: Practical means to prevent transmission** means good faith employment of an activity, behavior, method, or device that is scientifically demonstrated to measurably reduce the risk of transmitting a sexually transmitted disease, including but not limited to: The use of a condom, barrier protection, or other prophylactic device; or good faith participation in a treatment regimen prescribed by a health care provider or public health professional.

New Section 5 | PROS & CONS

- **GROSS MISDEAMEANOR:** Penalties of up to one year in jail and fines of up to \$5,000
 - Includes all the above and the Person *knowingly* misrepresents their infection status
 - **PROS:** The language of *knowingly* attempts to narrowing the net of egregious behaviors (lying)
 - **CONS:** Extremely difficult for a person to prove that they did disclose? It is nearly always one person's word against another.
 - What else?

New Section 5 | PROS & CONS

- C) Violation of this section doesn't require registration under RCW 9A.44.130
 - RCW 9A.44.130 refers to the code for sex offenders registration and procedures, but doesn't mention RCW 9.94A.835 and 9.94A.030 the special allegations and definition used to cause folks to be a sex offender.
 - The prosecuting attorney shall file a special allegation of sexual motivation in every criminal case, felony, gross misdemeanor, or misdemeanor, other than sex offenses as defined in RCW [9.94A.030](#) when sufficient admissible evidence exists, which, when considered with the most plausible, reasonably foreseeable defense that could be raised under the evidence, would justify a finding of sexual motivation by a reasonable and objective fact finder.
 - Note: There is no retroactive piece for prior convictions. That will have to be done that separately next year; or, if we can get agreement, as a companion bill this year.

Prosecuting Attorneys Association

- Want to narrow the Felony A statute.
- Wants to clarify “intent” in order to prosecute only those cases they believe to be specific intent to infect another person. “I want to infect others with HIV”.
- Wants to narrow the risks of wholesale prosecutions.
- However, has stated their continued support for a transmission penalties or a similar equivalence, based on the nature of HIV’s incurable disease state.
- Exceptionalism is warranted by those who would cause intentional, egregious behaviors.
- Supports the bifurcation of Public Health Statutes and Criminal Statutes.
- Current suggested substitute for “HIV” is “infectious disease with high morbidity or high mortality”. Broadens the possible scope of prosecuted diseases. Not consistent with treatable chronic medical condition.

What are the HPSG's next steps?

- DOH has approved and forwarded the package onto the Governor for his support.
- Is this proposal or NEW SECTION 5 our best efforts in working to:
 1. Eliminate HIV/AIDS exceptionalism,
 2. Improve access to preventive care,
 3. Ensure the efficacy of health orders for the control of sexually transmitted diseases, and
 4. Modernize the control of sexually transmitted diseases and blood-borne pathogens.
- Thoughts? Letter(s) of support?